

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

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FOR STATE
HEALTH DEPT.

(M)
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MEDICAL CERTIFICATION

MARYLAND STATE DEPARTMENT OF HEALTH																	
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND																	
12635 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12585																	
1. PLACE OF DEATH a. COUNTY <u>Harford</u> b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> c. LENGTH OF STAY IN 1b <u>11 yrs.</u> d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)						2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) a. STATE <u>MD</u> b. COUNTY <u>Harford</u> c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> d. STREET ADDRESS <u>R.D. #1</u> e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First <u>Enos</u> Middle <u>Baird</u> Last <u>Anderson</u>						4. DATE OF DEATH Month <u>November</u> Day <u>4</u> Year <u>1960</u>											
5. SEX <u>M</u>		6. COLOR OR RACE <u>W</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>SEPT. 26, 1893</u>		9. AGE (In years last birthday) <u>67</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u>		IF UNDER 24 HRS. Hours <u> </u> Min. <u> </u>					
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>MILLWORKER</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>STEEL</u>				11. BIRTHPLACE (State or foreign country) <u>McMECHEN, W.VA.</u>				12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>					
13. FATHER'S NAME <u>ENOS ANDERSON</u>						14. MOTHER'S MAIDEN NAME <u>ANNA BARTHOLOMEW</u>											
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, if known) <u>No</u> (If yes, give war or dates of service)						16. SOCIAL SECURITY NO. <u>213-07-8143</u>						17. INFORMANT <u>CLARA ANDERSON, WHITEFORD, MD.</u> Address <u> </u>					
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Arteriosclerotic disease</u> <u>422.1</u> DUE TO (b) <u> </u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (c) <u> </u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) <u> </u>												INTERVAL BETWEEN ONSET AND DEATH <u> </u>					
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/>						20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u> </u>											
20c. TIME OF INJURY Month, Day, Year Hour a.m. <u> </u> p.m. <u>19</u>				20d. INJURY OCCURRED While <input type="checkbox"/> Not While at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>		20f. (City or town) <u> </u> (County) <u> </u> (State) <u> </u>									
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D.						CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>											
EXAMINER'S NAME (Type) <u>Gerald C Palmer</u>						DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u> </u> DATE SIGNED <u>11-5-60</u>											
22a. BURIAL, CREMATION, or other disposal (Specify) <u>BURIAL</u>						22b. DATE THEREOF <u>11-7-60</u>		22c. NAME OF CEMETERY OR CREMATORY <u>TABERNACLE</u>		22d. LOCATION (City, town, or country) (State) <u>WHITEFORD, MD.</u>							
23. FUNERAL DIRECTOR <u>John H. Harding</u> ADDRESS <u>DELTA, PA.</u>						24a. REC'D BY REGISTRAR <u> </u> DATE <u>NOV 9 '60</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u>									

1952.03.03

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SEA-100-187

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MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12616

CERTIFICATE OF DEATH

12586

Reg. Dist. No.

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|---|---|--|---|
| 1. PLACE OF DEATH
a. COUNTY
<i>Baltimore Maryland</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
d. STATE
<i>Maryland</i> b. COUNTY
<i>Baltimore</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Harold Chase</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Harold Chase</i> | |
| c. LENGTH OF STAY IN 1b
<i>78 yrs.</i> | | d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>114 McPherson Drive</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>Nellie Boyd Backus</i> | | 4. DATE OF DEATH
Month <i>11</i> Day <i>26</i> Year <i>1960</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>11/6/1882</i> |
| 9. AGE (In years last birthday)
<i>78</i> yrs. | | 10. IF UNDER 1 YEAR
Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. <i>0</i> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House Wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>none</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Harold Chase</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>George G. Boyd</i> | | 14. MOTHER'S MAIDEN NAME
<i>Rose Lawder</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) <i>No</i> | | 16. SOCIAL SECURITY NO.
<i>Unknown</i> | |
| 17. INFORMANT
<i>Mr. Melvin Gordon Harold Chase</i> | | Address <i>114 McPherson Drive</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Decomposition</i>
443X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>arterio sclerotic Cardiovascular disease</i>
DUE TO (c) <i>Hypertension</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>3 yrs</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <i>19</i> p. m. | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office Bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from <i>June 11-26, 1960</i> , to <i>Nov 26, 1960</i> , that I last saw the deceased alive on <i>11-26, 1960</i> , and that death occurred at <i>8 A.M.</i> from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Edna H. Simon</i> | | ADDRESS (Street, city or town, state) DATE SIGNED
<i>114 McPherson Drive, Baltimore, Md.</i> <i>Nov 26, 1960</i> | |
| PHYSICIAN'S NAME (Type)
<i>E. J. SIMON</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<i>11/29/60</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>Angel Hill</i> | 22d. LOCATION (City, town, or county) (State)
<i>Harold Chase, Md.</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>James H. Simon</i> | | ADDRESS
<i>Harold Chase, Md.</i> | |
| 24a. REC'D BY REGISTRAR
DATE <i>DEC 5 '60</i> | | 24b. REGISTRAR'S SIGNATURE
<i>William S. Harris</i> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be returned by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE 19

Form 100-10

1912

PLACE IN CASE

REGISTRATION

CLERK OF THE COURT

1912

DATE OF DEATH
PLACE IN CASE

1912

DATE OF DEATH
PLACE IN CASE

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 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12587

12636

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|--|-------------------------------|--|---|--|--|--|--------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bel-air</i> | | c. LENGTH OF STAY IN 1b <i>Lifetime</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Rural Bel-air, md</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <i>Box 286 Route 1 Bel-air md</i> | | | | d. STREET ADDRESS <i>Box 286 Route 1 Bel-air</i> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <i>John</i> First <i>Barnes</i> Middle Last | | | | 4. DATE OF DEATH Month <i>11</i> Day <i>28</i> Year <i>1960</i> | | | |
| 5. SEX <i>Male</i> | 6. COLOR OR RACE <i>Negro</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>February 28, 1882</i> | | 9. AGE (In years last birthday) <i>78</i> yrs. | IF UNDER 1 YEAR Months <i>9</i> Days <i>x</i> Hours <i>x</i> Min. <i>x</i> | IF UNDER 24 HRS. Min. <i>x</i> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>Laborer</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>Stone Quarry</i> | | 11. BIRTHPLACE (State or foreign country) <i>Harford County, md</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U. S. A.</i> | |
| 13. FATHER'S NAME <i>No record</i> | | | | 14. MOTHER'S MAIDEN NAME <i>Emma Barnes</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>no</i> | | 16. SOCIAL SECURITY NO. <i>214-16-6986</i> | | 17. INFORMANT <i>Mrs Mary E. Barnes</i> Address <i>Box 286, Route 1 Bel-air, Maryland</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>LOBAR PNEUMONIA</i>
<i>490X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) <i>SILICOSIS</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH <i>5 DAYS</i> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>6/8/1953</i> to <i>11/28</i> 19 <i>60</i> that (I) (we) last saw the deceased alive on <i>11/28</i> 19 <i>60</i> and that death occurred at <i>11:28</i> P. M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE <i>Robert Barthel</i> | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <i>11/30/60</i> | |
| 22c. PHYSICIAN'S NAME (Type) <i>ROBERT BARTHEL</i> | | | | 22d. ADDRESS <i>Forest Hill, md</i> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i> | | 23b. DATE THEREOF <i>12/2/60</i> | | 23c. NAME OF CEMETERY OR CREMATORY <i>Clark's Chapel Cemetery</i> | | 23d. LOCATION (City, town, or county) (State) <i>Harford County md</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <i>Elmer E. Bullink</i> | | | | ADDRESS <i>Harford County, md</i> | | 25a. REC'D BY REGISTRAR <i>DEC 6 '60</i> | |
| | | | | 25b. REGISTRAR'S SIGNATURE <i>Arthur L. Hanna</i> | | | |

MEDICAL CERTIFICATION

CERTIFICATE OF DEATH

1901

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CHURCH OF THE LIVING

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12611

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

12588

| | | | |
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| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md</u>
b. COUNTY <u>Harpur</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bellaire</u> | c. LENGTH OF STAY IN 1b
<u>1 month</u> | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>Harford Convalescing Home</u> | | d. STREET ADDRESS <u>Andrews Road</u>
<u>1634 Andrews Road</u> | |
| 3. NAME OF DECEASED
(Type or print) <u>Theresa R. Binder</u>
First Middle Last | | 4. DATE OF DEATH
Month <u>November</u> Day <u>25</u> Year <u>1960</u> | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>5-11-81</u> |
| 9. AGE (In years last birthday)
<u>79</u> yrs. | | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | 11. BIRTHPLACE (State or foreign country)
<u>Unknown</u> |
| 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | | 13. FATHER'S NAME
<u>Unknown</u> | |
| 14. MOTHER'S MAIDEN NAME
<u>Unknown</u> | | 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | |
| 16. SOCIAL SECURITY NO.
<u>320 01 1568</u> | | 17. INFORMANT
<u>Robt. T. Binder, Aberdeen, Md.</u>
Address <u>634 Andrews Rd.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Arteriosclerotic CV disease</u>
<u>422.01</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.
(b) _____
(c) _____
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | INTERVAL BETWEEN ONSET AND DEATH
<u>2</u> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
<u>19</u> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>attended from</u> | 20f. (City or town) (County) (State)
<u>10-19-60 to 11-25-60</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE
<u>Gerald C. Palmer</u>
EXAMINER'S NAME (Type)
<u>Gerald C. Palmer, M.D.</u> | | CHIEF MEDICAL EXAMINER <input type="checkbox"/>
ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>
DEPUTY MEDICAL EXAMINER <input type="checkbox"/>
DATE SIGNED
<u>11-35-60</u> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | 22b. DATE THEREOF
<u>11/26/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Irving Pk. Blvd Cem. of Ill. Chicago, Ill.</u> | 22d. LOCATION (City, town, or county) (State)
<u>Ill.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Tarrington Funeral Home</u>
ADDRESS
<u>Aberdeen, Md.</u> | | 24a. REC'D BY REGISTRAR
DATE
<u>NOV 20 1960</u> | 24b. REGISTRAR'S SIGNATURE
<u>Gerald C. Palmer</u> |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please write the cause of death, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

BT 370M7245-171A

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12612

CERTIFICATE OF DEATH

Reg. Dist. No.

12589

| | | | |
|---|------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>BEL AIR</i> | | c. LENGTH OF STAY IN 1b
<i>Lifetime</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>EAST Broadway</i> | | e. STREET ADDRESS
<i>1 EAST Broadway</i> | |
| 3. NAME OF DECEASED (Type or print)
First <i>BESSIE</i> Middle <i>BOARMAN</i> Last <i>BOARMAN</i> | | 4. DATE OF DEATH
Month <i>NOVEMBER</i> Day <i>27</i> Year <i>1960</i> | |
| 5. SEX
<i>F</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>August 7, 1875</i> |
| 9. AGE (In years last birthday)
<i>85</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>Merchant</i> | | 10b. KIND OF BUSINESS OR INDUSTRY
<i>Hardware</i> | |
| 11. BIRTHPLACE (State or foreign country)
<i>Harford County, Maryland</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>BENJAMIN F. BOARMAN</i> | | 14. MOTHER'S MAIDEN NAME
<i>FRANCES E. HOLLAND</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <i>NO</i> (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. <i>—</i> | |
| 17. INFORMANT
<i>HERACE BOARMAN</i> Address <i>455 CHOICE STREET BEL AIR, Maryland</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Cerebral Thrombosis</i>
332X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>—</i> DUE TO (c) <i>—</i> | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 week</i> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>Nov. 27, 1960</i> to <i>Nov. 27, 1960</i> , that I last saw the deceased alive on <i>Nov. 27, 1960</i> , and that death occurred at <i>1:30 AM</i> , from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE
<i>Charles Richardson</i> | | ADDRESS (Street, city or town, state)
<i>126 S. Main Bel Air 11/25/60</i> | |
| DATE SIGNED
<i>11/25/60</i> | | | |
| PHYSICIAN'S NAME (Type)
<i>Joseph W. Foster</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 22b. DATE THEREOF
<i>Nov. 29, 1960</i> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<i>Rock Spring Episcopal Cem.</i> | | 22d. LOCATION (City, town, or county) (State)
<i>Forest Hill, Harford Co., Maryland</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>Joseph W. Foster</i> | | ADDRESS
<i>W. Broadway + Will. Ams St. BEL AIR, Maryland</i> | |
| 24a. REC'D BY REGISTRAR
<i>NOV 29 '60</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur S. ...</i> | |

CERTIFICATE OF DEATH

1915

1915

| | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|--------------------------|--|----------------------|--|-----------------------|--|--------------------------|--|----------------------|--|-----------------------|--|---------------------------|--|---------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Date of death | | 6. Place of death | | 7. Cause of death | | 8. Signature of physician | | 9. Signature of registrar | | 10. Signature of informant | |
| John Doe | | Male | | 45 | | Jan 1, 1910 | | Jan 15, 1915 | | Baltimore, Md. | | Heart disease | | [Signature] | | [Signature] | | [Signature] | |
| 11. Occupation | | 12. Education | | 13. Marital status | | 14. Religion | | 15. Usual residence | | 16. Usual occupation | | 17. Usual education | | 18. Usual marital status | | 19. Usual religion | | 20. Usual residence | |
| Teacher | | High School | | Married | | Roman Catholic | | Baltimore, Md. | | Teacher | | High School | | Married | | Roman Catholic | | Baltimore, Md. | |
| 21. Name of informant | | 22. Address of informant | | 23. Telephone number | | 24. Name of physician | | 25. Address of physician | | 26. Telephone number | | 27. Name of registrar | | 28. Address of registrar | | 29. Telephone number | | 30. Name of informant | |
| John Doe | | 123 Main St. | | 123-4567 | | Dr. Smith | | 456 Oak St. | | 456-7890 | | Mr. Jones | | 789 Elm St. | | 789-0123 | | John Doe | |

THIS CERTIFICATE IS VALID FOR THE PURPOSES OF THE MARYLAND DEPARTMENT OF HEALTH - BALTIMORE, MD

CERTIFICATE OF DEATH

Reg. Dist. No.

12590

12613

| | | | | | | | |
|--|----------------------------------|---|--|--|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air | | | | c. LENGTH OF STAY IN 1b
1 month | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
154 North Main Street | | | |
| 3. NAME OF DECEASED (Type or print)
First Roy Middle Jirdon Last Boggs | | | | 4. DATE OF DEATH
Month NOV Day 26 Year 1960 | | | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
NOV 5, 1901 | 9. AGE (In years last birthday)
57 yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | | IF UNDER 24 HRS.
Months Days Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farm employee | | 10b. KIND OF BUSINESS OR INDUSTRY
Gen. Farming | | 11. BIRTHPLACE (State or foreign country)
Renick, W. Va. | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Andrew Boggs | | | | 14. MOTHER'S MAIDEN NAME
Nettie M. Simmons | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
No | | 16. SOCIAL SECURITY NO.
183-18-6555 | | INFORMANT MacPhail, Rd. Bel Air, Md. | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CARDIO-RESP. FAILURE
200.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) LYMPHO-SARCOMA
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
20 HRS
3 MONTHS |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Sept , 19 48 , to 25 NOV , 19 60 , that I last saw the deceased alive on 25 NOV , 19 60 , and that death occurred at 4:15 A.M. from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
H. P. Sidwell | | M.D.
H. P. Sidwell M.D. | | ADDRESS (Street, city or town, state)
401 Franklin St. Bel Air | | DATE SIGNED
26 NOV 60 | |
| PHYSICIAN'S NAME (Type)
H. P. Sidwell M.D. | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11/28/1960 | | 22c. NAME OF CEMETERY OR CREMATORY
Bel Air Mem. Gardens | | 22d. LOCATION (City, town, or county) (State)
Bel Air, Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Charles E. Kurtz | | | | ADDRESS
Farmersville Md. | | 24a. REC'D BY REGISTRAR
DATE NOV 29 '60 | |
| | | | | 24b. REGISTRAR'S SIGNATURE
Charles E. Kurtz | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

AT 100114-41290 TO 100114-41291 (2)

152

1
FOR STATE
HEALTH DEPT.

TO DEPT. OF MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with permit PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
SM 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|---|--|---------------------------|--|---|--|---|--|---|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 12637 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 1. PLACE OF DEATH
e. COUNTY <u>Harford</u> MARYLAND | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Del Penna</u> b. COUNTY <u>Harford</u> <u>York</u> | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Whiteford</u> | | | | | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Woodbine</u> <u>75X-3</u> | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <u>Live Bridge Road</u> | | | | | | d. STREET ADDRESS <u>R.D.</u> | | | | | |
| 3. NAME OF DECEASED (Type or print) First <u>A.</u> Middle <u>Everett</u> Last <u>Boothe</u> | | | | | | 4. DATE OF DEATH Month <u>November</u> Day <u>29</u> Year <u>1960</u> | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>Apr. 11, 1939</u> | | 9. AGE (In years last birthday) <u>21</u> yrs. | | IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Farm laborer</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | 11. BIRTHPLACE (State or foreign country) <u>Delta, Pa.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>George Boothe</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Doris Rudd</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <u>No</u> (If yes give war or dates of service) | | | | | | 16. SOCIAL SECURITY NO. <u>207-30-5261</u> | | 17. INFORMANT <u>George Boothe, Woodbine, R.D., Pa.</u> Address | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture skull</u>
912-1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
DUE TO (c) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/> | | | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) <u>Tractor fell on him</u> | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>3</u> p.m. <u>11-29</u> 19 <u>60</u> | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Live Bridge Rd. Farm</u> | | 20f. (City or town) <u>Whiteford</u> (County) <u>Harford</u> (State) <u>MD.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Lowell C Palmer</u> | | | | | | CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u> | | | | | |
| EXAMINER'S NAME (Type) <u>Lowell C Palmer</u> | | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | | | | | | 22b. DATE THEREOF <u>Dec. 3, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Union Chapel</u> | | 22d. LOCATION (City, town, or country) (State) <u>Summerville, Pa.</u> | |
| 23. FUNERAL DIRECTOR <u>John H. Hawkins, Delta, Pa.</u> ADDRESS | | | | | | 24a. REC'D BY REGISTRAR <u>DEC 2 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Anthony J. Hume</u> | | | |

12891

STATE OF NEW YORK
IN SENATE
JANUARY 10, 1901
REPORT
OF THE
COMMISSIONERS OF THE
LAND OFFICE
IN RESPONSE TO A
RESOLUTION PASSED
BY THE SENATE
MAY 1, 1899
ALBANY:
J. B. LEECH, PRINTER.
1901.

1

1 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12617

CERTIFICATE OF DEATH

12592

Reg. Dist. No.

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Havre de Grace | | c. LENGTH OF STAY IN 1b | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
305 Wilson Street | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
WILLIAM FRANCIS BULL | | 4. DATE OF DEATH
Month November Day 1 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Sept. 18, 1879 |
| 9. AGE (In years last birthday) yrs. 81 | | 10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
U.S. Govt. | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
Franklin Francis Bull | | 14. MOTHER'S MAIDEN NAME
Sophia Elliott | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | |
| 17. INFORMANT
Mrs. Lula Bull, Havre de Grace, Md. | | Address 305 Wilson St. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) CEREBRO-VASCULAR ACCIDENT
DUE TO 331X
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) ARTERIO SCLEROSIS
DUE TO (c) | | | INTERVAL BETWEEN ONSET AND DEATH
2 years |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED
While of work <input type="checkbox"/> Not while of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that I attended the deceased from Oct. 25 , 19 60 , to Nov. 1 , 19 60 , that I last saw the deceased alive on Oct. 25 , 19 60 , and that death occurred at 6:10 AM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 421 Congress Ave. Havre de Grace, Md.
DATE SIGNED 11-3-60 | | | |
| ACTUAL SIGNATURE Gunther D. Hirsch M.D. | | PHYSICIAN'S NAME (Type) Gunther D. Hirsch, M.D. Havre de Grace, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/4/60 | 22c. NAME OF CEMETERY OR CREMATORY
Grove Cemetery | 22d. LOCATION (City, town, or county) (State)
Aberdeen, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring
ADDRESS
Aberdeen, Md. | | 24a. REC'D BY REGISTRAR
DATE NOV 7 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kress |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12618
CERTIFICATE OF DEATH

Reg. Dist. No.

12593

| | | | |
|---|-------------------------------|--|-----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford Maryland</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>Maryland</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <i>Harford Chase</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | d. STREET ADDRESS <i>1120 S. Washington</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <i>Helen J. Burns</i> First Middle Last | | 4. DATE OF DEATH <i>11/6/60</i> Month Day Year | |
| 5. SEX <i>Female</i> | 6. COLOR OR RACE <i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <i>9/18/1881</i> |
| 9. AGE (In years last birthday) <i>79</i> yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <i>House Wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY <i>—</i> | |
| 11. BIRTHPLACE (State or foreign country) <i>Harford Chase, Md.</i> | | 12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i> | |
| 13. FATHER'S NAME <i>Otto Green</i> | | 14. MOTHER'S MAIDEN NAME <i>Helen Bailey</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) <i>No</i> | | 16. SOCIAL SECURITY NO. <i>Unknown</i> | |
| 17. INFORMANT <i>Mrs. Louise Waller</i> Address <i>130 S. Washington</i> | | <i>Harford Chase, Md.</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Arterio Sclerotic Cardiac</i>
446X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <i>Chronic Arterio Sclerotic - nephritis</i>
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. 19
p. m. | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <i>12/15</i> , 19 <i>32</i> to <i>11/6</i> , 19 <i>60</i> , that I last saw the deceased alive on <i>11-6</i> , 19 <i>60</i> , and that death occurred at <i>8 A.</i> M., from the causes and on the date stated above.
ADDRESS (Street, city or town, state) <i>11/19/60</i> DATE SIGNED | | | |
| ACTUAL SIGNATURE <i>[Signature]</i> M.D. | | | |
| PHYSICIAN'S NAME (Type) <i>[Signature]</i> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <i>11/9/60</i> | | 22b. DATE THEREOF | |
| 22c. NAME OF CEMETERY OR CREMATORY <i>Angel Hill</i> | | 22d. LOCATION (City, town, or county) (State) <i>Harford Chase, Md.</i> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <i>Encourgin Rm, Harford Chase, Md.</i> | | 24a. REG'D BY REGISTRAR <i>NOV 9 '60</i> | |
| 24b. REGISTRAR'S SIGNATURE <i>Arthur S. Kraus</i> | | | |

TO DEPARTMENT OF HEALTH, MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any day is necessary, please indicate the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Medical Director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-43. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Give pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

V5. A15ME
5M 7/59

1
FOR STATE
HEALTH DEPT.

(M)

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | | | | | |
|---|--|--|--|---|--|--|--|--|--|--|--|--|--|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | | | | | |
| 12619 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | | | | | |
| 12594 | | | | | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>
c. LENGTH OF STAY IN 1b <u>MARYLAND</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>Any</u> b. COUNTY <u>Yavapai</u>
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Prescott</u>
d. STREET ADDRESS <u>1225 Rush St</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | | | | | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>Patricia A. Conboy</u> | | | | 4. DATE OF DEATH <u>November 13 1960</u> | | | | 5. SEX <u>Female</u> 6. COLOR OR RACE <u>White</u> 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> B. DATE OF BIRTH <u>April 14, 1941</u> 9. AGE (In years last birthday) <u>19</u> yrs. IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>S.A.U.S.N.</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>U.S. Navy</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Arizona</u> | | | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | | | |
| 13. FATHER'S NAME <u>Herman Oscar Conboy</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Agatha Lorraine Pike</u> | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>Yes, Feb. 1960-Nov. 1960</u> | | | | 16. SOCIAL SECURITY NO. <u>059-54-0650</u> | | | | 17. INFORMANT <u>U.S.N. Records, Bainbridge, Md.</u> | | | | Address | | | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Fracture cervicle vertebra</u>
812X DUE TO
Conditions, if any, which gave rise to immediate cause (e), stating the underlying cause last. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH. <u>Auto accident auto pedestrian type</u> | | | | 20b. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour <u>11-13</u> p.m. <u>1960</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not While <input checked="" type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>US 222</u> | | | | 20f. (City or town) <u>Port Deposit Pa</u> (County) <u>Md.</u> (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Lawrence C Palmer</u> | | | | M.D. <u>Gerold C Palmer MD</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Rel Air, Md</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | | | |
| EXAMINER'S NAME (Type) <u>Gerold C Palmer MD</u> | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | DATE SIGNED <u>11-13-60</u> | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, Removal <u>Removal</u> | | | | 22b. DATE THEREOF <u>11-15-1960</u> | | | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greenwood Memorial Cem. Phoenix, Arizona</u> | | | | 22d. LOCATION (City, town, or country) (State) | | | |
| 23. FUNERAL DIRECTOR <u>Lee A. Patterson</u> | | | | ADDRESS <u>Perryville, Md.</u> | | | | 24a. REC'D BY REGISTRAR <u>NOV 16 '60</u> | | | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled out, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

Item 20 Film 276 12-19-60
MAYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12620
CERTIFICATE OF DEATH

12595

| | | | |
|--|-------------------------------|--|---------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE MARYLAND b. COUNTY HARFORD | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAVRE DE GRACE | | c. LENGTH OF STAY IN 1b 24 DAYS | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp. | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) MATILDA First XXXXX Middle E. Last COOPER | | 4. DATE OF DEATH NOVEMBER 29 19 60 | |
| 5. SEX FEMALE | 6. COLOR OR RACE WHITE | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH Feb. 21, 1878 |
| 9. AGE (In years last birthday) 82 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife | | 10b. KIND OF BUSINESS OR INDUSTRY Home | |
| 11. BIRTHPLACE (State or foreign country) N.C. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 13. FATHER'S NAME BRYON SPENCER | | 14. MOTHER'S MAIDEN NAME CHARITY OSBOENE | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No | | 16. SOCIAL SECURITY NO. ** ** * | |
| 17. INFORMANT Bert Coomes, R.D. 2, Bel Air, Md. | | Address | |

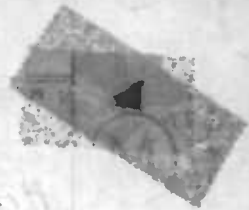
| | | | |
|--|---|--|--------------------------------------|
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 2° + 3° Body Burns (6590.)
916.9
Conditions, if any, which gave rise to immediate cause (a), stating the <u>underlying</u> cause lost.
DUE TO (b)
DUE TO (c) | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) Gas stove exploded, when lighting it. Suspected leak | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input checked="" type="checkbox"/> at work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 5 19 60 , to Nov. 29 19 60 , that (I) (we) last saw the deceased alive on Nov. 29 19 60 , and that death occurred at 4:15 M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE Frank D. Hauber | | 22b. DATE SIGNED 11/30/60 | |
| 22c. PHYSICIAN'S NAME (Type) Frank D. Hauber, M.D. | | 22d. ADDRESS 610 S. Union Ave, Havre de Grace, Md. | |

| | | | |
|---|----------------------------------|--|---|
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | 23b. DATE THEREOF 12/2/60 | 23c. NAME OF CEMETERY OR CREMATORY Oak Grove Baptist Cem. R.D., Bel Air, Maryland | 23d. LOCATION (City, town, or county) (State) |
| 24. FUNERAL DIRECTOR'S SIGNATURE John F. Tarring | | 25a. REC'D BY REGISTRAR DEC 7 '60 | |
| ADDRESS Tarring Funeral Home Aberdeen, Md. | | 25b. REGISTRAR'S SIGNATURE Arthur L. Hauber | |

1880

ESTIMATE OF DEATH

1880



Family Name: [illegible]
Given Name: [illegible]
Sex: [illegible]
Age: [illegible]
Date of Birth: [illegible]
Place of Birth: [illegible]
Occupation: [illegible]
Religion: [illegible]
Marital Status: [illegible]
Education: [illegible]
Social Status: [illegible]
Other Information: [illegible]

1

[Faint, illegible text continues in the lower half of the page, likely bleed-through from the reverse side.]

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. _____

12596

| | | | |
|--|---|---|---|
| 1. PLACE OF DEATH
o. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Havre de Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Havre de Grace</u> | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<u>518 Washington St</u> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED
(Type or print) <u>Percy E. Davis</u> | | 4. DATE OF DEATH <u>November 29 1960</u> | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>12/6/1895</u> |
| 9. AGE (In years last birthday)
<u>65</u> yrs. | | 10. IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | 11. IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Owner Davis Capstan Shop</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Adelstein Brothers Maryland</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>George H. Davis</u> | | 14. MOTHER'S MAIDEN NAME
<u>Adeline Lilly</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(If yes, give year & dates of service)
<u>WW II</u> | | 16. SOCIAL SECURITY NO.
<u>Unknown</u> | |
| 17. INFORMANT
<u>Mrs. William H. Davis</u> | | Address
<u>518 D. Washington Harford State, Md</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Poisoning</u> <u>Poisoning due to CO</u>
<u>891.0</u> DUE TO
Conditions, if any, which gave rise to immediate cause (b) <u> </u>
(c), stating the underlying cause last. DUE TO (c) <u> </u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u>Started car in very small closed garage</u> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. <u>11/29/60</u> 19 | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input checked="" type="checkbox"/> of work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u>Garage</u> | 20f. (City or town) (County) (State)
<u>Havre de Grace Harf Md.</u> |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> | | M.D. CHIEF MEDICAL EXAMINER <u>Bel Air, Md.</u> DATE SIGNED <u>11-29-60</u> | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer - MD</u> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> | |
| | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL CREMATION, REMOVAL (Specify)
<u>Burial</u> | 22b. DATE THEREOF
<u>12/2/60</u> | 22c. NAME OF CEMETERY OR CREMATORY
<u>Longest Hill</u> | 22d. LOCATION (City, town, or county) (State)
<u>Harford County, Md.</u> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>James H. Palmer</u> | | 24a. REC'D BY REGISTRAR
DATE <u>DEC 5 '60</u> | 24b. REGISTRAR'S SIGNATURE
<u>James H. Palmer</u> |

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your records.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the registrar prior to burial, cremation, or removal.

STATE OF TEXAS
 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12821

| | | | | | |
|--|--|---|--|--|--|
| NAME OF DECEASED
[Faint handwritten name] | | SEX
[Faint handwritten sex] | | AGE
[Faint handwritten age] | |
| DATE OF DEATH
[Faint handwritten date] | | TIME OF DEATH
[Faint handwritten time] | | PLACE OF DEATH
[Faint handwritten place] | |
| OCCASION OF DEATH
[Faint handwritten occasion] | | CAUSE OF DEATH
[Faint handwritten cause] | | MANNER OF DEATH
[Faint handwritten manner] | |
| SIGNATURE OF MEDICAL EXAMINER
[Faint handwritten signature] | | SIGNATURE OF WITNESS
[Faint handwritten signature] | | SIGNATURE OF DECEASED
[Faint handwritten signature] | |
| CITY OF DEATH
[Faint handwritten city] | | COUNTY OF DEATH
[Faint handwritten county] | | STATE OF DEATH
[Faint handwritten state] | |
| DECEASED'S RESIDENCE
[Faint handwritten address] | | DECEASED'S OCCUPATION
[Faint handwritten occupation] | | DECEASED'S MARITAL STATUS
[Faint handwritten status] | |
| DECEASED'S BIRTH DATE
[Faint handwritten date] | | DECEASED'S BIRTH PLACE
[Faint handwritten place] | | DECEASED'S BIRTH COUNTRY
[Faint handwritten country] | |
| DECEASED'S RACE
[Faint handwritten race] | | DECEASED'S COLOR
[Faint handwritten color] | | DECEASED'S RELIGION
[Faint handwritten religion] | |
| DECEASED'S EDUCATION
[Faint handwritten education] | | DECEASED'S INCOME
[Faint handwritten income] | | DECEASED'S SOCIAL SECURITY NUMBER
[Faint handwritten number] | |
| DECEASED'S MOTHER'S MARRIAGE DATE
[Faint handwritten date] | | DECEASED'S MOTHER'S MARRIAGE PLACE
[Faint handwritten place] | | DECEASED'S MOTHER'S MARRIAGE COUNTRY
[Faint handwritten country] | |
| DECEASED'S MOTHER'S RACE
[Faint handwritten race] | | DECEASED'S MOTHER'S COLOR
[Faint handwritten color] | | DECEASED'S MOTHER'S RELIGION
[Faint handwritten religion] | |
| DECEASED'S MOTHER'S EDUCATION
[Faint handwritten education] | | DECEASED'S MOTHER'S INCOME
[Faint handwritten income] | | DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER
[Faint handwritten number] | |
| DECEASED'S MOTHER'S MARRIAGE DATE
[Faint handwritten date] | | DECEASED'S MOTHER'S MARRIAGE PLACE
[Faint handwritten place] | | DECEASED'S MOTHER'S MARRIAGE COUNTRY
[Faint handwritten country] | |
| DECEASED'S MOTHER'S RACE
[Faint handwritten race] | | DECEASED'S MOTHER'S COLOR
[Faint handwritten color] | | DECEASED'S MOTHER'S RELIGION
[Faint handwritten religion] | |
| DECEASED'S MOTHER'S EDUCATION
[Faint handwritten education] | | DECEASED'S MOTHER'S INCOME
[Faint handwritten income] | | DECEASED'S MOTHER'S SOCIAL SECURITY NUMBER
[Faint handwritten number] | |

BOMB

Handwritten signature/initials

Handwritten text at bottom right

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 1,2 FilmG274 11-14-60 et

CERTIFICATE OF DEATH

12597

Reg. Dist. No.

| | | | |
|---|----------------------------------|---|---|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Street</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Street(rural)</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>At home</u> | | d. STREET ADDRESS
<u>---</u> | |
| e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <u>James</u> Middle <u>P.</u> Last <u>Heckman</u> | | 4. DATE OF DEATH
Month <u>Nov</u> Day <u>4</u> Year <u>1960</u> | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Dec. 5, 1873</u> |
| 9. AGE (In years last birthday)
<u>86</u> yrs. | | IF UNDER 1 YEAR
Months <u>4</u> Days <u>1</u> Hours <u>19</u> Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Retired</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Harford Md</u> | |
| 11. BIRTHPLACE (State or foreign country)
<u>USA</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>James P. Heckman</u> | | 14. MOTHER'S MAIDEN NAME
<u>Elizabeth Thompson</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>No</u> | |
| 17. INFORMANT
<u>Wm. Heckman</u> | | Address
<u>Harlington</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Uremia</u>
<u>422.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Chronic Cardio-vascular Disease</u>
DUE TO (c) <u>10 yrs.</u> | | INTERVAL BETWEEN ONSET AND DEATH
<u>?</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY
Hour <u>19</u> Month <u>Nov</u> Day <u>4</u> Year <u>1960</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>Nov 1</u> , 19 <u>49</u> , to <u>Nov 4</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Nov 3</u> , 19 <u>60</u> , and that death occurred at <u>7:20 A.M.</u> from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED | | | |
| ACTUAL SIGNATURE <u>Willard P. Hudson</u> M.D. | | Forest Hill, Maryland Nov. 4, 1960 | |
| PHYSICIAN'S NAME (Type)
<u>WILLARD P. HUDSON, M.D.</u>
<u>Forest Hill, Maryland</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Nov 7, 1960</u> | | 22b. DATE THEREOF
<u>Nov 7, 1960</u> | |
| 22c. NAME OF CEMETERY OR CREMATORY
<u>Heublin Cem</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Harford Co, Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>H. S. Bailey</u> | | ADDRESS
<u>Harlington</u> | |
| 24a. REC'D BY REGISTRAR
DATE <u>NOV 9 '60</u> | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Knaus</u> | |

1
 MARYLAND STATE DEPARTMENT OF HEALTH
 DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
 CERTIFICATE OF DEATH

12622

12598

| | | | | | | | |
|--|----------------------------------|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Hartford</i> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <i>Md.</i> b. COUNTY <i>Hartford</i> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Havre de Grace</i> | | c. LENGTH OF STAY IN 1b
<i>2 days</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Whiteford</i> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Hartford Memorial Hospital</i> | | | | d. STREET ADDRESS
<i>1</i> | | e. IS RESIDENCE ON A FARM?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <i>Goldie</i> Middle <i>Irene</i> Last <i>DuBree</i> | | | | 4. DATE OF DEATH
Month <i>November</i> Day <i>27</i> Year <i>1960</i> | | | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>White</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<i>Apr. 22 1907</i> | | 9. AGE (In years last birthday) <i>53</i> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>HOUSEWIFE</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country)
<i>Ohio, USA</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>Garrett Handley</i> | | | | 14. MOTHER'S MAIDEN NAME <i>(SMITH)</i>
<i>Attie Handley</i> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
(If yes, give war or dates of service) | | 17. INFORMANT
Address
<i>STANLEY DuBREE, WHITEFORD, MD.</i> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Shock + fluid imbalance</i>
<i>561.5</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Intestinal Obstruction</i>
DUE TO (c) <i>Exacerbated hernia (5 days)</i> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<i>1 day</i>
<i>5 days</i>
<i>5 days</i> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <i>Dealtos quincy unrequited</i> | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>19</i> to <i>11-27</i> , 19 <i>60</i> that (I) <i>met last</i> saw the deceased alive on <i>11-27</i> 19 <i>60</i> , and that death occurred at <i>10:30</i> A.M. from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<i>Wm. F. Dwyer</i> | | | | 22b. DATE SIGNED | | 22c. PHYSICIAN'S NAME (Type)
<i>Havre de Grace</i> | |
| 22a. SIGNATURE | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/> | | 22d. ADDRESS
<i>Havre de Grace</i> | | 22b. DATE SIGNED | |
| 23a. BURIAL, CREMATION, or REMOVAL (Specify)
<i>BURIAL</i> | | 23b. DATE THEREOF
<i>11-30-60</i> | | 23c. NAME OF CEMETERY OR CREMATORY
<i>DARLINGTON</i> | | 23d. LOCATION (City, town, or county) (State)
<i>DARLINGTON, MD.</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>John H. Harkins, Delta, Pa.</i> | | | | 25a. REC'D BY REGISTRAR
DATE <i>NOV 29 '60</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur L. Hines</i> | |

MEDICAL CERTIFICATION

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12623

12599

| | | | | | | | |
|--|----------------------------------|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Hartford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>Hartford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Harre de Grace</u> | | c. LENGTH OF STAY IN lb
<u>3 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Aberdeen</u> <u>31</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>Hartford Memorial Hosp.</u> | | | | d. STREET ADDRESS
<u>414 Park Street 1</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last
<u>Rebecca</u> <u>Five</u> | | | | 4. DATE OF DEATH Month Day Year
<u>November 27 1960</u> | | | |
| 5. SEX
<u>Female</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
<u>May 28, 1884</u> | | 9. AGE (In years last birthday) <u>76</u> yrs. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Home</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Russia</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>USA</u> | |
| 13. FATHER'S NAME
<u>Morris Schneider</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u>
Anna (Schneider) Fine | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | 16. SOCIAL SECURITY NO. (If yes, give war or dates of service) | | 17. INFORMANT Address
<u>Fred Fine, 414 Parke, Aberdeen, Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebro Vascular Accident</u>
DUE TO <u>Hypertension</u>
(b) <u>Arterio Sclerotic heart disease</u>
DUE TO <u>331X</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>3 days</u>
<u>10 years</u>
<u>5 years</u> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Aug 15 1960</u> to <u>Nov 25 1960</u> , that (I) (we) last saw the deceased alive on <u>Nov 25 1960</u> and that death occurred at <u>11 AM</u> from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>Andre Weiss MD</u> | | | | 22b. DATE SIGNED
<u>Nov 27/60</u> | | 22c. PHYSICIAN'S NAME (Type)
<u>Andre' Weiss, M.D.</u> | |
| 22d. ADDRESS
<u>114 W. Bel Air Ave. Aberdeen, Md.</u> | | 22e. REC'D BY REGISTRAR
<u>DEC 1 '60</u> | | 22f. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Removal</u> | | 23b. DATE THEREOF
<u>11/28/60</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>Both Hope Lawn Cemetery</u> | | 23d. LOCATION (City, town, or county) (State)
<u>Carriek, Penna.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>John F. Tarring</u> | | | | 24b. ADDRESS
<u>Tarring Funeral Home Aberdeen, Md.</u> | | | |

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1930

CERTIFICATE OF DEATH

1930



1
FOR STATE
HEALTH DEPT.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
12639 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 12600

| | | | |
|---|---|--|--|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution; Residence before admission)
a. STATE <i>MD</i> b. COUNTY <i>Harford</i> | |
| b. CITY OR TOWN <i>Street</i> (If outside corporate limits, write RURAL and give nearest town) | | c. CITY OR TOWN <i>X Street</i> (If outside corporate limits, write RURAL and give nearest town) | |
| d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)
<i>Bay Road</i> | | d. STREET ADDRESS
<i>1 Bay Road</i> | |
| 3. NAME OF DECEASED
(Type or print) <i>Frank</i> First Middle <i>PAUL</i> Last <i>Gaines</i> | | 4. DATE OF DEATH
Month <i>November</i> Day <i>30</i> Year <i>1960</i> | |
| 5. SEX <i>M</i> | 6. COLOR OR RACE <i>W</i> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>May 18 1892</i> 68 yrs. |
| 9. AGE (In years last birthday) | | 10. IF UNDER 1 YEAR
Months <i>11</i> Days <i>12</i> Hours <i>0</i> Min. | 11. IF UNDER 24 HRS.
Months <i>0</i> Days <i>0</i> Hours <i>0</i> Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>FARMER</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<i>MARYLAND</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>USA</i> | |
| 13. FATHER'S NAME
<i>WILLIAM H. GAINES</i> | | 14. MOTHER'S MAIDEN NAME
<i>JANE GREEN</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>YES</i> | | 16. SOCIAL SECURITY NO.
<i>220-30-0932</i> | |
| 17. INFORMANT
<i>MRS MATILDA M. GAINES</i> | | Address
<i>STREET, MD</i> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>25 W Cerebrum</i>
<i>976X</i> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) DUE TO
(c) | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING CAUSE OF DEATH.
<input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<i>Shot self with rifle</i> | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <i>11-30</i> p. m. 19 <i>60</i> | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<i>Bay Road</i> | 20f. (City or town) (County) (State)
<i>Street Harford MD</i> |
| 21. I certify that I took charge of the remains described above, held on Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input checked="" type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | |
| ACTUAL SIGNATURE
<i>Derald C Palmer</i> | | M.D. CHIEF MEDICAL EXAMINER <input type="checkbox"/> <i>Bel Air MD</i> DATE SIGNED | |
| EXAMINER'S NAME (Type)
<i>Gerald C Palmer M.D.</i> | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) | 22b. DATE THEREOF
<i>DEC. 3-1960</i> | 22c. NAME OF CEMETERY OR CREMATORY
<i>LOUDON PARK CEMETERY</i> | 22d. LOCATION (City, town, or county) (State)
<i>BALTIMORE MD</i> |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<i>BURGEE FUNERAL HOME 3631 FALLS ROAD</i> | | 24a. REC'D BY REGISTRAR
DATE <i>DEC 2 '60</i> | |
| ADDRESS
<i>Horace F. Burgee BALTIMORE 11</i> | | 24b. REGISTRAR'S SIGNATURE
<i>Arthur L. Kraus</i> | |

MEDICAL CERTIFICATION

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please execute this certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.



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1
FOR STATE
HEALTH DEPT. (M)
TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please call the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the Registrar. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health or its designated agent, prior to burial, cremation, or removal, and any event within 72 hours after death.
VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-------------------------------------|--|--|--|--|--|--|--|---|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 12640 MEDICAL EXAMINER'S CERTIFICATE OF DEATH | | | | | | | | | | | |
| 12601 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> <u>MARYLAND</u> | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Harford</u> | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fallston</u> | | | | c. LENGTH OF STAY IN 1b <u>years</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Fallston</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Pleasantville Rd</u> | | | | d. STREET ADDRESS <u>Pleasantville Rd</u> | | | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) <u>Marie Louise Livens</u> | | | | 4. DATE OF DEATH <u>November 23 1960</u> | | | | | | | |
| 5. SEX <u>F</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>June 19-1904</u> | | 9. AGE (In years last birthday) <u>56</u> yrs. | | IF UNDER 1 YEAR Months Days IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Army Chem.</u> | | | | 11. BIRTHPLACE (State or foreign country) <u>Handley W. Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u> | |
| 13. FATHER'S NAME <u>George Irvin Gellispie</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Ida Dell Chapman</u> | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | 16. SOCIAL SECURITY NO. <u>220-20-7134</u> | | | | 17. INFORMANT <u>Paula Livens</u> Address <u>Fallston Md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>443x</u> IMMEDIATE CAUSE (a) <u>Hypertensive C.V. disease</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } DUE TO (b)
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| 2Da. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | 2Db. DESCRIBE HOW INJURY OCCURED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a.m. p.m. <u>19</u> | | | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>
CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, Md.</u>
ACTUAL SIGNATURE <u>Lorald C Palmer</u> M.D. ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED
EXAMINER'S NAME (Type) <u>Geordie Palmer MD</u> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> <u>11-23-60</u>
Address (Street, city, town, or county) | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u> | | 22b. DATE THEREOF <u>Nov. 26-60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Mountain Christian</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>Joppa Md</u> | | | |
| 23. FUNERAL DIRECTOR <u>W.H. Archer, Benson, Md.</u> ADDRESS | | | | | | 24a. REC'D BY REGISTRAR <u>NOV 28 60</u> DATE | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

CASE STUDY

1 FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

12641 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12602

| | | | | | | | |
|--|------------------------------|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Bel Air</u> | | c. LENGTH OF STAY IN 1b
<u>10 yrs.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X Bel Air</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>RD 2 Box 61</u> | | | | d. STREET ADDRESS
<u>1 IPD 2</u> | | | |
| 3. NAME OF DECEASED (Type or print)
<u>Robert Lincoln Gullion</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>9</u> Year <u>1960</u> | | | |
| 5. SEX
<u>M</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>May, 2, 1904</u> | | 9. AGE (In years last birthday)
<u>56</u> yrs. | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> | IF UNDER 24 HRS.
Hours <u> </u> Min. <u> </u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Laborer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Smith Co., Va.,</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.,</u> | |
| 13. FATHER'S NAME
<u>William J. Gullion</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Mary L. Turner</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)
<u>no</u> | | 16. SOCIAL SECURITY NO.
<u>223-20-0480</u> | | 17. INFORMANT
<u>Anna I. Gullion</u> Address <u>Bel Air R.D., Md.,</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b) <u> </u> DUE TO <u> </u> (c) <u> </u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u> </u> | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour <u> </u> e.m. <u> </u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, W</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-9-60</u> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county)
<u> </u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>Nov. 12, 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Oak Grove</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Bel Air Harford Md.,</u> | |
| 23. FUNERAL DIRECTOR
<u>Howard K. McComas</u> | | | | ADDRESS
<u>Abingdon, Md.,</u> | | 24a. REC'D BY REGISTRAR
DATE <u>NOV 15 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Hanna</u> | | | |

THE STATE
OF NEW YORK



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12624

STATE OF MARYLAND
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12603

| | | | | | | | |
|---|--|---|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE | | | | c. LENGTH OF STAY IN 1b 2 DAYS | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) DEUARD M HACKLER | | | | 4. DATE OF DEATH NOVEMBER 9 1960 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH May 26, 1904 | |
| 9. AGE (In years last birthday) 56 yrs. | | IF UNDER 1 YEAR Months Days | | IF UNDER 24 HRS. Hours Min. | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Truck Operator | | | | 10b. KIND OF BUSINESS OR INDUSTRY Transport Co. | | 11. BIRTHPLACE (State or foreign country) Virginia | |
| 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | | | | | |
| 13. FATHER'S NAME BRUCE HACKLER | | | | 14. MOTHER'S MAIDEN NAME Cynthia Hash | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. 216-01-1659 | | 17. INFORMANT Mrs. Deuard M. Hackler, Bel Air, Md. Address RD. 2, B.255 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c)]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Paralytic ileus
581.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Acute + subacute pancreatitis
DUE TO (c) Alcoholism | | | | INTERVAL BETWEEN ONSET AND DEATH 2 days
2 weeks
? | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) Cirrhosis of the liver | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) <input type="checkbox"/> | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from Nov. 7th, 1960 to Nov. 9th, 1960 that (I) (we) last saw the deceased alive on Nov. 9th, 1960 and that death occurred at 4:10 AM , from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE Edward C. Loo, M.D. | | | | 22b. DATE SIGNED Nov. 10th, 1960 | | 22c. PHYSICIAN'S NAME (Type) Edward C. Loo, M.D. | |
| 22d. ADDRESS 211 North Union Ave, Haure de Grace Md. | | | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 23b. DATE THEREOF 11/11/60 | | 23c. NAME OF CEMETERY OR CREMATORY Bel Air Memorial Gardens, Bel Air, Maryland | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John G. Tarring | | | | 25a. REC'D BY REGISTRAR NOV 14 '60 | | 25b. REGISTRAR'S SIGNATURE John G. Tarring | |

1-2-15

VS. A15ME
5M 7/59

MARYLAND STATE DEPARTMENT OF HEALTH

Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12604

| | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
|--|--|------------------------------------|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|--|----------------------------|--|--|--|--|----------------------------|--|--|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | | | | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE Maryland b. COUNTY Harford | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Edgewood | | | | | | | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
Edgewood | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
51 Battle Street | | | | | | | | | | d. STREET ADDRESS
51 Battle Street | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 3. NAME OF DECEASED
(Type or print)
First CONSTANCE Middle LAJOYCE Last HILL | | | | | | | | | | 4. DATE OF DEATH
Month November Day 1 Year 19 60 | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 5. SEX
Female | | 6. COLOR OR RACE
Colored | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
August 20, 1960 | | 9. AGE (In years last birthday) yrs. 2 Months 11 | | IF UNDER 1 YEAR
Hours 11 Min. | | IF UNDER 24 HRS.
Hours 11 Min. | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Infant | | | | | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | | | | | | | | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 13. FATHER'S NAME
Eddie Hill | | | | | | | | | | 14. MOTHER'S MAIDEN NAME
Alma Hall, Edgewood, Maryland | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) | | | | | | | | | | 16. SOCIAL SECURITY NO. 17. INFORMANT Address | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
492X IMMEDIATE CAUSE (a) Interstitial pneumonitis
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. } (b)
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | | | | | | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH | | | | | | | | | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. | | | | | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. p.m. 19 | | | | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not While <input type="checkbox"/>
at work <input type="checkbox"/> at work <input type="checkbox"/> | | | | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | | 20f. (City or town) (County) (State) | | | | | | | | | | | | | | | | | | | | | | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> . Inspection <input type="checkbox"/> . Inquiry <input type="checkbox"/> . and in my opinion death resulted from: <u>Natural causes</u> <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined manner <input type="checkbox"/> | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| ACTUAL SIGNATURE Charles S. Petty | | | | | | | | | | M.D. ASSISTANT MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | | | | | | DEPUTY MEDICAL EXAMINER <input type="checkbox"/> | | | | | | | | | | DATE SIGNED 11/2/60 | | | | | | | | | |
| EXAMINER'S NAME (Type)
Charles S. Petty, M.D. | | | | | | | | | | Address (Street, city, town, or county) | | | | | | | | | | | | | | | | | | | | | | | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | | | | 22b. DATE THEREOF
11/3/60 | | | | | 22c. NAME OF CEMETERY OR CREMATORY
Fairview Cemetery | | | | | 22d. LOCATION (City, town, or country) (State)
Harford County Maryland | | | | | | | | | | | | | | | | | | | | | | | | |
| 23. FUNERAL DIRECTOR
Elmer E. Bulluck | | | | | | | | | | ADDRESS
Harford County | | | | | | | | | | 24a. REC'D BY REGISTRAR | | | | | 24b. REGISTRAR'S SIGNATURE | | | | | | | | | | | | | | |

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

12625

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12605

| | | | |
|---|--|--|---|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
o. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre de Grace</u> | | c. LENGTH OF STAY IN 1b <u>1/2 hr</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Alpha</u> Middle <u>Keien</u> Last <u>Keien</u> | | 4. DATE OF DEATH Month <u>November</u> Day <u>10</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>White</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>5/20/1893</u> |
| 9. AGE (In years lost birthday) <u>67</u> yrs. | | 10. IF UNDER 1 YEAR Months <u></u> Days <u></u> Hours <u></u> Min. <u></u> | 11. IF UNDER 24 HRS. Min. <u></u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>none</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>Marlington, W. Va.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Gasper Enoch</u> | | 14. MOTHER'S MAIDEN NAME <u>Martha Clayton</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>Unknown</u> | |
| 17. INFORMANT <u>Boy Kevin</u> Address <u>134 Gresham St. Harre de Grace Md.</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Conchaic Failure</u>
420.0 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Myocardial Infarction</u>
(c) <u>Arterio Sclerotic Heart Disease</u> | | | INTERVAL BETWEEN ONSET AND DEATH
<u>1 day</u>
<u>1 day</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | 20d. INJURY OCCURRED While <input type="checkbox"/> of work Not while <input type="checkbox"/> of work | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) (County) (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/8</u> to <u>11/10</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 10</u> 19 <u>60</u> , and that death occurred at <u>10:45</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>John L. Wadsworth</u> M.D. | | 22b. DATE SIGNED <u>11/11/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | 23b. DATE THEREOF <u>11/13/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Principio</u> | 23d. LOCATION (City, town, or county) (State) <u>Principio Md.</u> |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Lawrence L. Hanrahan</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 14 '60</u> | |
| | | 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Harris</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

CERTIFICATE OF DEATH

Reg. Dist. No. 12606

12643

| | | | |
|--|---------------------------|--|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) rocks | | c. LENGTH OF STAY IN 1b 2 years | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) Charles G. Koether | | 4. DATE OF DEATH November 6 1960 | |
| 5. SEX M | 6. COLOR OR RACE W | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH June 14 1888 |
| 9. AGE (In years last birthday) 72 yrs. | | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Retired | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) Balto. Md. | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME Geo. E.A. Koether | | 14. MOTHER'S MAIDEN NAME Catherine M. Kusterer | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) -- (If yes, give war or dates of service) -- | | 16. SOCIAL SECURITY NO. -- | |
| 17. INFORMANT Frederick Wm. Koether | | Address 2816 Alvarado Sq. 14 | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Arteriosclerotic CV Disease
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | INTERVAL BETWEEN ONSET AND DEATH 1 year | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from Nov. 1 , 19 59 , to Nov. 6 , 19 60 that I last saw the deceased alive on Oct. 30 , 19 60 , and that death occurred at 11 A. M. from the causes and on the date stated above. | | | |
| ACTUAL SIGNATURE Gerald C. Palmer M.D. | | ADDRESS (Street, city or town, state) Bel Air, Md. DATE SIGNED 11-6-60 | |
| PHYSICIAN'S NAME (Type) Gerald C. Palmer M.D. | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | 22b. DATE THEREOF Nov. 9, 1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY Lorraine Cem. | | 22d. LOCATION (City, town, or county) (State) Balto. Md. | |
| 23. FUNERAL DIRECTOR'S SIGNATURE Philip Henry Sons | | 24a. REC'D BY REGISTRAR NOV 9 1960 ADDRESS 2024 Orleans St. 31 | |
| | | 24b. REGISTRAR'S SIGNATURE Arthur S. Hines | |

CERTIFICATE OF DEATH

12843

FILE NO.

DATE

PLACE

SEX

AGE

EDUCATION

OCCUPATION

RELIGION

DATE OF BIRTH

PLACE OF BIRTH

DATE OF DEATH

PLACE OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

DATE OF INTERMENT

PLACE OF INTERMENT

NAME OF FUNERAL HOME

NAME OF MINISTER

NAME OF CLERGYMAN

NAME OF CHURCH

NAME OF CEMETERY

NAME OF BURIAL

NAME OF CREMATION

NAME OF URN

NAME OF CASK

NAME OF COFFIN

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

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NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

NAME OF CASKET

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please advise the Director, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M 7/59

MEDICAL CERTIFICATION

| MARYLAND STATE DEPARTMENT OF HEALTH | | | | | | | | | | | |
|--|--|-----------------------------------|--|--|--|---|--|---|---|--|--|
| Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND | | | | | | | | | | | |
| 12620 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12607 | | | | | | | | | | | |
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u>
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Harford</u>
c. LENGTH OF STAY IN <u>MD.</u>
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>Harford Memorial Hospital</u> | | | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission)
a. STATE <u>MD.</u> b. COUNTY <u>Harford</u>
c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Bel Air</u>
d. STREET ADDRESS <u>1549 Cherry Road</u>
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | |
| 3. NAME OF DECEASED (Type or print) <u>A</u> <u>nastasios</u> <u>E</u> <u>Kourniotis</u>
First Middle Last | | | | | | 4. DATE OF DEATH <u>November 23</u> <u>1960</u>
Month Day Year | | | | | |
| 5. SEX <u>M</u> | | 6. COLOR OR RACE <u>W</u> | | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH <u>1886</u> <u>7</u> <u>14</u>
Yrs. Months Days | | 9. AGE (In years last birthday) <u>74</u> yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Retired</u> | | | | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>RESTAURANT</u> | | | 11. BIRTHPLACE (State or foreign country) <u>Greece</u> | | |
| 13. FATHER'S NAME <u>Elias Kourniotis</u> | | | | | | 14. MOTHER'S MAIDEN NAME <u>Helen</u> | | | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> | | | | | | 16. SOCIAL SECURITY NO. <u>214409580</u> | | 17. INFORMANT <u>JOHN KANAIS</u> | | Address <u>3822 Glen Arm Ave (C)</u> <u>BALTO.</u> | |
| 18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)
PART I. DEATH WAS CAUSED BY, IMMEDIATE CAUSE (a) <u>Compound, comminuted fractures both bones both legs</u>
825X DUE TO <u>bones both legs</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO (b) (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) (b) (c)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | | | | | |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH. <u>Auto accident</u> | | | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour <u>7</u> a.m. <u>11-23</u> 19 <u>60</u> p.m. | | | | 20d. INJURY OCCURRED While <input checked="" type="checkbox"/> Not While <input type="checkbox"/> at work <input type="checkbox"/> at work <input checked="" type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>Buy + Frensin St.</u> | | 20f. (City or town) <u>Bel Air</u> (County) <u>Harford</u> (State) <u>MD.</u> | | | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | | | | | |
| ACTUAL SIGNATURE <u>Gerald C Palmer</u> M.D. | | | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Bel Air, MD.</u> | | | DATE SIGNED <u>11-24-60</u> | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer - M.D.</u> | | | | | | DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | | 22b. DATE THEREOF <u>11/26/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY <u>Greek Ortho. Cem.</u> | | | | 22d. LOCATION (City, town, or country) (State) <u>BALTIMORE MD.</u> | | | |
| 23. FUNERAL DIRECTOR <u>L. J. RUCK</u> <u>5305 HARFORD ROAD</u> | | | | | | 24a. REC'D BY REGISTRAR <u>NOV 28 '60</u> | | 24b. REGISTRAR'S SIGNATURE <u>Arthur S. Kraus</u> | | | |

STANDARD FORM NO. 64

0274-3359/94/0005-0000\$05.00/0

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12627

DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12608

| | | | |
|--|------------------------------|---|--------------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <i>Harford</i> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <i>md</i> b. COUNTY <i>Cecil</i> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Harpe-de-Grace</i> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<i>Port Deposit</i> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<i>Harford Memorial Hospital</i> | | d. STREET ADDRESS
<i>R.D. I</i> | |
| e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print)
First <i>Mary</i> Middle <i>B.</i> Last <i>Linton</i> | | 4. DATE OF DEATH
Month <i>11</i> Day <i>18</i> Year <i>1960</i> | |
| 5. SEX
<i>Female</i> | 6. COLOR OR RACE
<i>W</i> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<i>3-10-1880</i> |
| 9. AGE (In years lost birthday)
<i>80</i> yrs. | | 10. IF UNDER 1 YEAR
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<i>House-wife</i> | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country)
<i>md</i> | | 12. CITIZEN OF WHAT COUNTRY?
<i>U.S.A.</i> | |
| 13. FATHER'S NAME
<i>George W. Brown</i> | | 14. MOTHER'S MAIDEN NAME
<i>Annie Isaac</i> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<i>No</i> | | 16. SOCIAL SECURITY NO.
<i>217-07-0890</i> | |
| 17. INFORMANT
<i>Mrs Philip Morrison, Perryville, Md.</i> | | Address | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <i>Coronary Thrombosis</i>
DUE TO <i>Diabetes</i>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <i>Generalized Arteriosclerosis</i>
DUE TO (c) <i>Generalized Arteriosclerosis</i>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | |
| INTERVAL BETWEEN ONSET AND DEATH
<i>10 days</i>
<i>2 yrs</i>
<i>10 yrs</i> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. <i>19</i> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <i>Jan 4</i> 19 <i>50</i> , to <i>Nov 18</i> 19 <i>60</i> , that (I) (we) lost saw the deceased alive on <i>Nov 18</i> 19 <i>60</i> , and that death occurred at <i>7:40</i> P.M. from the causes and on the date stated above. | | | |
| 22a. SIGNATURE
<i>G.H. Richards Jr.</i> | | 22b. DATE SIGNED
<i>11/19/60</i> | |
| 22c. PHYSICIAN'S NAME (Type)
<i>G.H. Richards Jr. M.D.</i> | | 22d. ADDRESS
<i>Port Deposit, Md.</i> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<i>Burial</i> | | 23b. DATE THEREOF
<i>11-21-1960</i> | |
| 23c. NAME OF CEMETERY OR CREMATORY
<i>Asbury</i> | | 23d. LOCATION (City, town, or county) (State)
<i>Port Deposit, Md. Rural</i> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<i>Lee A. Patterson, Sons</i> | | ADDRESS
<i>Perryville, Md</i> | |
| 25a. REC'D BY REGISTRAR
DATE <i>NOV 22 '60</i> | | 25b. REGISTRAR'S SIGNATURE
<i>Arthur S. Hines</i> | |

12004

CERTIFICATE OF DEATH

12004

1

TO HOSPITAL, OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

12644

CERTIFICATE OF DEATH

Reg. Dist. No.

12609

| | | | |
|--|----------------------------------|---|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Md. b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Jarrettsville | | c. LENGTH OF STAY IN 1b
5 yrs. | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First EDWARD Middle HERMAN Last MARCELLE | | 4. DATE OF DEATH
Month November Day 9 Year 1960 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
Dec. 30, 1881 |
| 9. AGE (In years less birthday)
78 yrs. | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS.
Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Mill Wright | | 10b. KIND OF BUSINESS OR INDUSTRY
Slate | |
| 11. BIRTHPLACE (State or foreign country)
Vermont | | 12. CITIZEN OF WHAT COUNTRY?
USA | |
| 13. FATHER'S NAME
Nelson Marcelle | | 14. MOTHER'S MAIDEN NAME
Alvira Capman | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
008-07-8837 | |
| 17. INFORMANT
Mrs Edw. Marcelle (wife) | | Address
Jarrettsville, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Acute pulmonary edema (acute congestive heart failure) 15 min.
422.1 DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.
(b) Decompensated chronic cardio-vascular disease & 4 yrs.
DUE TO Chr. pulmonary fibrosis and emphysema 15 yrs.
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED
While <input type="checkbox"/> Not while <input type="checkbox"/> of work <input type="checkbox"/> of work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from June , 1950, to Nov. 9 , 1961, that I last saw the deceased alive on Nov. 3 , 1960, and that death occurred 8:35 p.m. from the causes and on the date stated above.
ADDRESS (Street, city or town, state) DATE SIGNED
Willard P. Hudson M.D. Forest Hill, Maryland 11-9-60
ACTUAL SIGNATURE
PHYSICIAN'S NAME (Type) Willard P. Hudson | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 22b. DATE THEREOF
11-12-1960 | |
| 22c. NAME OF CEMETERY OR CREMATORY
Belair Gardens | | 22d. LOCATION (City, town, or county) (State)
Belair, Maryland | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
Haskins T. Home | | 24a. REC'D BY REGISTRAR
NOV 14 '60 | |
| ADDRESS
Delta, Penna. | | 24b. REGISTRAR'S SIGNATURE
William S. Farris | |

CERTIFICATE OF DEATH

| | | | | | | | | | | | | | | | | | | | | | | | |
|-----------------------|--|------------------|--|--------------|--|------------------|--|-------------------|--|------------------|--|------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|----------------------------|--|
| 1. Name of deceased | | 2. Sex | | 3. Age | | 4. Date of birth | | 5. Place of birth | | 6. Date of death | | 7. Place of death | | 8. Cause of death | | 9. Manner of death | | 10. Signature of physician | | 11. Signature of registrar | | 12. Date of registration | |
| John Doe | | Male | | 45 | | Jan 1, 1900 | | Boston, Mass. | | Jan 15, 1945 | | Boston, Mass. | | Heart disease | | Natural | | [Signature] | | [Signature] | | Jan 16, 1945 | |
| 13. Name of informant | | 14. Relationship | | 15. Address | | 16. City | | 17. State | | 18. Country | | 19. Date of completion | | 20. Signature of informant | | 21. Signature of registrar | | 22. Date of registration | | 23. Date of completion | | 24. Signature of registrar | |
| Jane Doe | | Wife | | 123 Main St. | | Boston | | Mass. | | U.S.A. | | Jan 16, 1945 | | [Signature] | | [Signature] | | Jan 16, 1945 | | Jan 16, 1945 | | [Signature] | |



CERTIFICATE OF DEATH

Reg. Dist. No.

12610

12645

| | | | | | | | |
|---|---------------------------|--|-------------------------------------|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md.</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Leuch</u> | | | | c. LENGTH OF STAY IN 1b <u>3 yrs.</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>-</u> | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>Junious MARK Mustard</u> | | | | 4. DATE OF DEATH Month Day Year <u>Nov. 3 1960</u> | | | |
| 5. SEX <u>male</u> | 6. COLOR OR RACE <u>w</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Jan 16 1892</u> | | 9. AGE (In years last birthday) <u>68</u> yrs. | IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>habocec</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Shoe Co.</u> | | 11. BIRTHPLACE (State or foreign country) <u>White Gate Va</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>James H. Mustard</u> | | | | 14. MOTHER'S MAIDEN NAME <u>Hattie E. Price</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>216-12-6632A</u> | | 17. INFORMANT Address <u>Mrs Junious Mustard</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Acute Coronary Thrombosis</u>
DUE TO <u>Coronary Arteriosclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>5 yrs</u>
(c) _____
INTERVAL BETWEEN ONSET AND DEATH <u>5 yrs</u> | | | | | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) _____ | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> at work Not while <input type="checkbox"/> at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | |
| | | | | 20f. (City or town) _____ (County) _____ (State) _____ | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 21. I certify that I attended the deceased from <u>Mar 3</u> , 19 <u>58</u> , to <u>Nov 3</u> , 19 <u>60</u> , that I last saw the deceased alive on <u>Oct 21</u> , 19 <u>60</u> , and that death occurred at <u>4 A.</u> M, from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE <u>Dudley Phillips</u> | | | | ADDRESS (Street, city or town, state) <u>DARLINGTON</u> DATE SIGNED _____ | | | |
| PHYSICIAN'S NAME (Type) <u>Dudley Phillips MD</u> | | | | M.D. <u>MARYLAND</u> | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 3, 1960</u> | | | | 22b. NAME OF CEMETERY OR CREMATORY <u>Rock Run Cem</u> | | 22d. LOCATION (City, town, or county) (State) <u>Harford Co Md</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE <u>H & Bailey</u> | | | | ADDRESS <u>Darlington Md</u> | | 24a. REC'D BY REGISTRAR <u>NOV 9 '60</u> 24b. REGISTRAR'S SIGNATURE <u>Caroline S. Hume</u> | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

CERTIFICATE OF DEATH

| | |
|--|--|
| <p>1. Name of deceased: <u>JOHN J. BROWN</u></p> | |
| <p>2. Sex: <u>Male</u></p> | |
| <p>3. Date of birth: <u>1914</u></p> | |
| <p>4. Place of birth: <u>MASSACHUSETTS</u></p> | |
| <p>5. Date of death: <u>1945</u></p> | |
| <p>6. Place of death: <u>MASSACHUSETTS</u></p> | |
| <p>7. Cause of death: <u>Heart Disease</u></p> | |
| <p>8. Duration of illness: <u>Several days</u></p> | |
| <p>9. Name of physician: <u>Dr. J. J. Brown</u></p> | |
| <p>10. Name of informant: <u>John J. Brown</u></p> | |
| <p>11. Address of informant: <u>123 Main St, Boston, Mass.</u></p> | |
| <p>12. Signature of informant: <u>[Signature]</u></p> | |
| <p>13. Date of completion: <u>1945</u></p> | |



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9-59

12628

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12611

| | | | | | | | |
|---|--|--|--|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY HARFORD | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) HAURE DE GRACE 1 DAY 20THS | | | | c. LENGTH OF STAY IN 1b 31 | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION HARFORD Memorial Hosp. | | | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 3. NAME OF DECEASED (Type or print) First Middle Last JOSEPH PATRICK NORD JR. | | | | 4. DATE OF DEATH Month Day Year NOVEMBER 1 19 60 | | | |
| 5. SEX MALE | | 6. COLOR OR RACE WHITE | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH 10-31-60 | |
| 9. AGE (In years last birthday) yrs. 1 | | 10. IF UNDER 1 YEAR Months 1 Days 20 | | 11. IF UNDER 24 HRS. Hours 20 Min. | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) NEWBORN | | | | 10b. KIND OF BUSINESS OR INDUSTRY | | | |
| 11. BIRTHPLACE (State or foreign country) Maryland | | | | 12. CITIZEN OF WHAT COUNTRY? U.S.A. | | | |
| 13. FATHER'S NAME Joseph Patrick Nord | | | | 14. MOTHER'S MAIDEN NAME Anna Popovich | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) | | | | 16. SOCIAL SECURITY NO. | | | |
| 17. INFORMANT Address | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) 773.5 Hyaline Membrane Disease
DUE TO Prematurity
Conditions, if any, which gave rise to immediate cause (a), stating the under-lying cause lost. (b) Prematurity
DUE TO (c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19 | | | | 20d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/> | | | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | | 20f. (City or town) (County) (State) | | | |
| 21. I certify that (I) (this hospital) attended the deceased from 10/31/60 to 11/1/60 , that (I) (we) last saw the deceased alive on 11/1/60 and that death occurred at 11/2/60 M, from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE St. Clare MD | | | | 22b. DATE SIGNED 11/2/60 | | | |
| 22c. PHYSICIAN'S NAME (Type) | | | | 22d. ADDRESS | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) Burial | | | | 23b. DATE THEREOF 11/3/60 | | | |
| 23c. NAME OF CEMETERY OR CREMATORY Post Cemetery | | | | 23d. LOCATION (City, town, or county) (State) Aberdeen Proving Gr. Md. | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE John G. Barring - Aberdeen, Maryland | | | | 25a. REC'D BY REGISTRAR DATE NOV 7 '60 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE William S. Harris | | | |

2271292XV2

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Items 8, 9, Film G276 12-12-60 et

CERTIFICATE OF DEATH

12612

Reg. Dist. No.

| | | | |
|---|--------------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY Harford MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY Harford | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air, (Rural) | | c. LENGTH OF STAY IN 1b
X CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
Bel Air (Rural) | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
R.D. #2, | | e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First WILLIAM Middle WALTER Last PIEPER | | 4. DATE OF DEATH
Month November Day 25 Year 19 60 | |
| 5. SEX
Male | 6. COLOR OR RACE
White | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
1888 August 3, 1888 |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Horticulturist | | 10b. KIND OF BUSINESS OR INDUSTRY
Nursery | |
| 11. BIRTHPLACE (State or foreign country)
Maryland | | 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | |
| 13. FATHER'S NAME
John Henry Pieper | | 14. MOTHER'S MAIDEN NAME
Alberta Thompson | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)
No | | 16. SOCIAL SECURITY NO.
218-03-9832 | |
| 17. INFORMANT
Mrs. W.W. Pieper, | | Address R.D. #2, Bel Air, Md. | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Carcinoma of lung, left
163 X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO
(c)
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)
19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | INTERVAL BETWEEN ONSET AND DEATH
5 mos. |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year
Hour o. m. p. m. 19 | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from 6-28 , 19 60 , to 11-25 , 19 60 , that I last saw the deceased alive on 11-25-60 , 19 60 , and that death occurred at 5:50 PM from the causes and on the date stated above.
ADDRESS (Street, city or town, state) 617 W. Bel Air Ave. DATE SIGNED 11-26-60 | | | |
| ACTUAL SIGNATURE B. J. Plunkett Jr. M.D. | | PHYSICIAN'S NAME (Type) B. J. Plunkett Jr. M.D. Aberdeen, Md. | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | 22b. DATE THEREOF
11/28/60 | 22c. NAME OF CEMETERY OR CREMATORY
Spesutia Cemetery | 22d. LOCATION (City, town, or county) (State)
Perryman, Maryland |
| 23. FUNERAL DIRECTOR'S SIGNATURE
John G. Tarring | | 24a. REC'D BY REGISTRAR
NOV 30 '60 | 24b. REGISTRAR'S SIGNATURE
Arthur S. Kraus |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be used by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
15M 9/59

12647

CERTIFICATE OF DEATH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12613

| | | | |
|--|---------------------------------|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlottesville</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Charlottesville</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) <u>Wm. H. Prusherry</u> First Middle Last | | 4. DATE OF DEATH <u>Nov. 22</u> Month Day Year | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>Colored</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>Dec. 5 1880</u> yrs. |
| 9. AGE (In years last birthday) <u>79</u> yrs. | | 10. IF UNDER 1 YEAR Months Days | 11. IF UNDER 24 HRS. Hours Min. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>laborer on farm</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Harford Co., Md.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>U.S.A.</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>Robert Prusherry</u> | | 14. MOTHER'S MAIDEN NAME <u>Unknown</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no or unknown) <u>no</u> | | 16. SOCIAL SECURITY NO. <u>2-13-12-334</u> | |
| 17. INFORMANT <u>Marcus Prusherry</u> Address <u>Charlottesville, Md.</u> | | 18. INTERVAL BETWEEN ONSET AND DEATH <u>2 hrs</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>331X</u> DUE TO <u>Arterio Sclerosis</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>Cerebral Hemorrhage</u> DUE TO <u>above</u> (c) <u>above</u> | | | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Heart Condition</u> | | | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Nov 15</u> 19 <u>60</u> to <u>Nov 22</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 15</u> 19 <u>60</u> and that death occurred at <u>2</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>F. P. Snodgrass</u> M.D. ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/25/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>F. P. Snodgrass M.D.</u> | | 22d. ADDRESS <u>Charlottesville Md</u> | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Nov. 26, 1960, Hasanna Cem</u> | | 23b. DATE THEREOF | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Harford Co., Md.</u> | | 23d. LOCATION (City, town, or county) (State) | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>H. S. Bailey</u> ADDRESS <u>Charlottesville, Md</u> | | 25a. REC'D BY REGISTRAR DATE <u>NOV 29 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Arthur S. Frame</u> | | | |

1941

MAINTAIN A RECORD OF HEALTH
CERTIFICATE OF DEATH
1941

1

CHIEF JUDGE

FOR COURT

CHIEF JUDGE

MEDICAL CERTIFICATION

VR A15 (4)
ISM 9/59

15820

Harold

Harold de Grace 2 days

Harold de Grace 2 days

Thomas

Male White

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

Harold de Grace 2 days

1
FOR STATE
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If any delay is necessary, please state the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.
TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Board of Health, or its designated agent, prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS. A15ME
5M/7/59

MARYLAND STATE DEPARTMENT OF HEALTH
Division of STATISTICAL RESEARCH AND RECORDS, 301 W. PRESTON STREET, BALTIMORE 1, MARYLAND
12614 MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12615

| | | | | | | | |
|---|------------------------------|---|---|--|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission)
a. STATE <u>md</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>Belt Air</u> | | | | c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town)
<u>X Joppa</u> | | | |
| d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address)
<u>Office Dr Jewel C Palmer</u> | | | | d. STREET ADDRESS
<u>1 Shirley Ave</u> | | | |
| 3. NAME OF DECEASED
(Type or print)
<u>Linda Marie Pineholt</u> | | | | 4. DATE OF DEATH
Month <u>November</u> Day <u>1</u> Year <u>1960</u> | | | |
| 5. SEX
<u>F</u> | 6. COLOR OR RACE
<u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>July 8, 1960</u> | | 9. AGE (in years last birthday)
yrs. <u>4</u> | IF UNDER 1 YEAR
Months <u>4</u> Days <u>4</u> | IF UNDER 24 HRS.
Hours <u>4</u> Min. <u>4</u> |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>None</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>None</u> | | 11. PLACE OF DEATH (State or foreign country)
<u>Harford Memorial Hospital</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.</u> | |
| 13. FATHER'S NAME
<u>Ralph Pineholt</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Virginia Lucas</u> | | | |
| 15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <input checked="" type="checkbox"/> | | 16. SOCIAL SECURITY NO.
<u>✓</u> | | 17. INFORMANT
<u>Ralph Pineholt</u>
Address <u>Joppa, Maryland Rd md</u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (e), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Prematurity</u>
<u>776X</u>
DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. }
(b) DUE TO
(c) | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>-</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (e) | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input type="checkbox"/> |
| 20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> or CONTRIBUTING CAUSE OF DEATH. <input type="checkbox"/> | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a.m. <u>19</u> p.m. <u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not While at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/> | | | | | | | |
| ACTUAL SIGNATURE <u>Jewel C Palmer</u> | | | | CHIEF MEDICAL EXAMINER <input type="checkbox"/> <u>Belt Air, md</u> | | | |
| EXAMINER'S NAME (Type) <u>Gerald C Palmer M.D.</u> | | | | ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED <u>11-1-60</u> | | | |
| DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/> | | | | Address (Street, city, town, or county) | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>4th Nov. 1960</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Glen Haven Cemetery</u> | | 22d. LOCATION (City, town, or country) (State)
<u>Glen Burnie, Md</u> | |
| 23. FUNERAL DIRECTOR
<u>R. V. Singleton</u> | | | | 24a. REC'D BY REGISTRAR
<u>Glen Burnie, Md</u> | | | |
| ADDRESS
<u>Glen Burnie, Md</u> | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Kaus</u> | | DATE
<u>NOV 3 '60</u> | |

2071221XV2

1581 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

1

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12630

12616

| | | | | | | | |
|---|----------------------------------|---|---|---|--|--|--|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Maryland</u> b. COUNTY <u>Harford</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Harvude Grace</u> | | c. LENGTH OF STAY IN 1b
<u>44 days</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>24 Harvude Grace</u> | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
<u>HARFORD MEMORIAL HOSPITAL</u> | | | | d. STREET ADDRESS
<u>1518 Bourbon St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print)
First <u>Charles</u> Middle <u>Bartol</u> Last <u>Silver</u> | | | | 4. DATE OF DEATH
Month <u>11</u> Day <u>21</u> Year <u>1960</u> | | | |
| 5. SEX
<u>Male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>FEB. 6, 1925</u> | | 9. AGE (In years lost birthday) yrs. <u>35</u> | IF UNDER 1 YEAR
Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Insurance Clerk</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Insurance</u> | | 11. BIRTHPLACE (State or foreign country)
<u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>US</u> | |
| 13. FATHER'S NAME
<u>L. Bartol Silver</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Ida Lowell</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
<u> </u> | | 16. SOCIAL SECURITY NO.
<u> </u> | | 17. INFORMANT
<u> </u> Address <u> </u> | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cachexia</u>
<u>202.1</u> DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>lymphoblastoma</u>
DUE TO (c) <u> </u> | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
<u>4 1/2 yrs</u> |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u> </u> | | | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)
<u> </u> | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. <u> </u> p. m. <u> </u> 19 <u>60</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)
<u> </u> | | 20f. (City or town) (County) (State)
<u> </u> <u> </u> <u> </u> | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Oct</u> 19 <u>60</u> , to <u>Nov</u> 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 21</u> 19 <u>60</u> , and that death occurred at <u>4 p.</u> M., from the causes and on the date stated above. | | | | | | | |
| 22a. SIGNATURE
<u>E. J. Simon</u> | | | | ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>
M.D. <u> </u> | | 22b. DATE SIGNED
<u>11-23-60</u> | |
| 22c. PHYSICIAN'S NAME (Type)
<u>E. J. SIMON</u> | | | | 22d. ADDRESS
<u>Harvude Grace, Md</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
<u>BURIAL</u> | | 23b. DATE THEREOF
<u>Nov. 22, 1960</u> | | 23c. NAME OF CEMETERY OR CREMATORY
<u>ROCK HON CEM.</u> | | 23d. LOCATION (City, town, or county) (State)
<u>HARFORD</u> <u>MD</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
<u>R. Madison Mitchell</u> | | | | ADDRESS
<u>HARVUDE GRACE, MD</u> | | 25a. REC'D BY REGISTRAR
DATE <u>NOV 28 '60</u> | |
| | | | | 25b. REGISTRAR'S SIGNATURE
<u>Cassius S. Thomas</u> | | | |

2

BP

12830

CERTIFICATE OF DEATH

MASSACHUSETTS DEPARTMENT OF HEALTH
DIVISION OF VITAL RECORDS AND STATISTICS

1. Name of deceased: Charles Joseph
2. Date of death: Nov 22 1922
3. Place of death: at home
4. Cause of death: La grippe

5. Name of physician: Dr. J. J. [illegible]
6. Name of informant: [illegible]
7. Address of informant: [illegible]
8. Name of registrar: [illegible]
9. Date of registration: [illegible]
10. Signature of registrar: [illegible]

12648

CERTIFICATE OF DEATH

Reg. Dist. No.

| | | | | | | | |
|---|----------------------------------|---|--|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MARYLAND</u> b. COUNTY <u>HARFORD</u> | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>Rural Pylesville</u> | | c. LENGTH OF STAY IN 1b
<u>6-1/2 mo.</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
<u>X Pylesville Rural</u> | | d. IS RESIDENCE ON A FARM?
YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION | | | | d. STREET ADDRESS
<u>1 HARKINS ROAD</u> | | | |
| 3. NAME OF DECEASED
(Type or print) First Middle Last
<u>WICK LEVIE SPURLIN</u> | | | | 4. DATE OF DEATH
Month Day Year
<u>NOV 19 1960</u> | | | |
| 5. SEX
<u>male</u> | 6. COLOR OR RACE
<u>White</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>
WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH
<u>Feb 20 1882</u> | 9. AGE (In years last birthday)
<u>78</u> yrs. | IF UNDER 1 YEAR
Months Days Hours Min. | IF UNDER 24 HRS. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
<u>Farmer</u> | | 10b. KIND OF BUSINESS OR INDUSTRY
<u>Gen. Farm</u> | | 11. BIRTHPLACE (State or foreign country)
<u>Sparta N.C.</u> | | 12. CITIZEN OF WHAT COUNTRY?
<u>U.S.A.</u> | |
| 13. FATHER'S NAME
<u>Eli Spurlin</u> | | | | 14. MOTHER'S MAIDEN NAME
<u>Emmaline Hudson</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES?
(Yes, no, or unknown) (If yes, give war or dates of service)
<u>No</u> | | 16. SOCIAL SECURITY NO.
<u>218-32-5128</u> | | INFORMANT
<u>Mrs. Zedie Spurlin</u> | | Address
<u>Pylesville Md.</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>Cerebral hemorrhage</u>
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>Carcinoma of stomach</u>
DUE TO (c) <u>metastasis</u> | | | | | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour a. m. p. m.
<u>19</u> | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that I attended the deceased from <u>January, 1960</u> to <u>19 November, 1960</u> , that I last saw the deceased alive on <u>19 November, 1960</u> , and that death occurred at <u>11:50 P.M.</u> from the causes and on the date stated above. | | | | | | | |
| ACTUAL SIGNATURE
<u>Reginald B. Gemmill</u> M.D. | | | | ADDRESS (Street, city or town, state) DATE SIGNED
<u>Stewartstown, Pa. 11/20/60</u> | | | |
| PHYSICIAN'S NAME (Type)
<u>REGINALD B. GEMMILL</u> | | | | | | | |
| 22a. BURIAL, CREMATION, REMOVAL (Specify)
<u>Burial</u> | | 22b. DATE THEREOF
<u>11/24/60</u> | | 22c. NAME OF CEMETERY OR CREMATORY
<u>Hooker</u> | | 22d. LOCATION (City, town, or county) (State)
<u>Sparta N.C.</u> | |
| 23. FUNERAL DIRECTOR'S SIGNATURE
<u>Charles C. Kutz</u> | | | | ADDRESS
<u>Jarrettsville Md.</u> | | 24a. REC'D BY REGISTRAR
DATE <u>NOV 22 '60</u> | |
| | | | | 24b. REGISTRAR'S SIGNATURE
<u>Arthur S. Krawa</u> | | | |

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use on the burial-transit permit. Then please remove corban papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)
15M 9/59

12631

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12618

| | | | | | |
|---|---|--|---|---|--|
| 1. PLACE OF DEATH
a. COUNTY <u>HARFORD</u> MARYLAND | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Md</u> b. COUNTY <u>Peel</u> ✓ | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>HAUCE DE GRACE</u> | | c. LENGTH OF STAY IN 1b <u>24 hrs</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Port Deposit</u> <u>07X-2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | | d. STREET ADDRESS <u>224 N. Main St.</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> |
| 3. NAME OF DECEASED (Type or print) First <u>PATRICIA</u> Middle <u>ANN</u> Last <u>STAMPS</u> | | | 4. DATE OF DEATH Month <u>November</u> Day <u>8</u> Year <u>1960</u> | | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>C</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>January 13, 1939</u> | | 9. AGE (In years last birthday) <u>21</u> yrs. |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>HOUSE WIFE</u> | | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Md</u> | | 11. BIRTHPLACE (State or foreign country) <u>U.S.</u> |
| 13. FATHER'S NAME <u>LeRoy Taylor</u> | | | 14. MOTHER'S MAIDEN NAME <u>HANNAH SMITH</u> | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>no</u> (If yes, give war or dates of service) <u>-</u> | | | 16. SOCIAL SECURITY NO. <u>213-36-9959</u> | | |
| 17. INFORMANT <u>Mrs. Hannah J. Taylor, Port Deposit, Md.</u> | | | Address <u>224 N. Main St.</u> | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
<u>675X</u> IMMEDIATE CAUSE (a) <u>Post Partum Hemorrhage & Macrocytic Anemia</u>
DUE TO
(b) <u>Vaginal Laceration</u>
DUE TO
(c) <u>Uterine Atony</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. | | | | | INTERVAL BETWEEN ONSET AND DEATH |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | 19. WAS AUTOPSY PERFORMED? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | |
| 20c. TIME OF INJURY Month, Day, Year
Hour a. m. p. m. 19 | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | 20f. (City or town) | (County) | (State) |
| 21. I certify that (I) (this hospital) attended the deceased from <u>11/6</u> , 19 <u>60</u> , to <u>11/8</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>Nov 8</u> , 19 <u>60</u> , and that death occurred at <u>6:55</u> AM, from the causes and on the date stated above. | | | | | |
| 22a. SIGNATURE <u>George T. Stansbury</u> | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED <u>11/10/60</u> | |
| 22c. PHYSICIAN'S NAME (Type) <u>George T. Stansbury</u> | | 22d. ADDRESS <u>569 Revolution St. Hauc de Grace, Md.</u> | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u> | 23b. DATE THEREOF <u>11/12/60</u> | 23c. NAME OF CEMETERY OR CREMATORY <u>Berkley Cemetery</u> | | 23d. LOCATION (City, town, or county) <u>Darlington, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Obelia J. Bullock, Hauc de Grace, Md.</u> | | ADDRESS | | 25a. REC'D BY REGISTRAR <u>DATE NOV 14 '60</u> | 25b. REGISTRAR'S SIGNATURE <u>C. J. King</u> |

12881
12882

CERTIFICATE OF DEATH

Post Positive Hemorrhage & Myocardial Infarction
Vascular Lesions
Lobular Atrophy

George A. Stansbury
President Stansbury

11/1/50

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be filed by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR AIS (4)
ISM 9/59

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12632
MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
CERTIFICATE OF DEATH

12619

| | | | | | | | | | |
|--|--|---|--|--|--|--|--|---|--|
| 1. PLACE OF DEATH
a. COUNTY HARFORD MARYLAND | | | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE Maryland b. COUNTY HARFORD | | | | | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town)
HAURE DE GRACE | | | | c. LENGTH OF STAY IN 1b
3 DAYS | | | | | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION
HARFORD Memorial Hosp. | | | | d. STREET ADDRESS
1222 PARKE | | | | | |
| 3. NAME OF DECEASED (Type or print)
First Edward Middle I Last Tobin | | | | 4. DATE OF DEATH
Month November Day 10 Year 1960 | | | | | |
| 5. SEX
MALE | | 6. COLOR OR RACE
White | | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | | 8. DATE OF BIRTH
Sept. 16, 1890 | | | |
| 9. AGE (In years last birthday)
70 yrs. | | IF UNDER 1 YEAR
Months 70 Days 70 Hours 70 Min. | | IF UNDER 24 HRS.
Months 70 Days 70 Hours 70 Min. | | | | | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)
Farmer (Retired) | | | | 10b. KIND OF BUSINESS OR INDUSTRY
Farm | | 11. BIRTHPLACE (State or foreign country)
Maryland | | | |
| 12. CITIZEN OF WHAT COUNTRY?
U.S.A. | | | | | | | | | |
| 13. FATHER'S NAME
Jerry Tobin | | | | 14. MOTHER'S MAIDEN NAME
CATHERINE BROWN | | | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown)
None | | | | 16. SOCIAL SECURITY NO.
222 S. Parke | | | | | |
| 17. INFORMANT
Jerry W. Tobin, Aberdeen, Maryland | | | | | | | | | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) Cerebral hemorrhage
331X DUE TO
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Cerebral arteriosclerosis DUE TO
(c) ~ sign | | | | | | | | INTERVAL BETWEEN ONSET AND DEATH
1 day | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | | | | | | | 19. WAS AUTOPSY PERFORMED?
YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | | | | | |
| 20c. TIME OF INJURY
Month, Day, Year
Hour o. m. p. m.
19 | | | | 20d. INJURY OCCURRED
While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | | |
| 20f. (City or town)
Chw 9 | | | | 20g. (County)
Chw 10 | | 20h. (State)
1960 | | | |
| 21. I certify that (I) (the hospital) attended the deceased from Nov 9 19 60 , to Nov 10 19 60 , that (I) (we) last saw the deceased alive on Nov 10 19 60 , and that death occurred at 255 M, from the causes and on the date stated above. | | | | | | | | | |
| 22a. SIGNATURE
B. J. Plunkett Jr. | | | | M.D. ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/> | | 22b. DATE SIGNED
11-11-60 | | | |
| 22c. PHYSICIAN'S NAME (Type)
B. J. Plunkett Jr., M.D. | | | | 22d. ADDRESS
617 W. Bel Air Ave, Aberdeen, Md. | | | | | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify)
Burial | | 23b. DATE THEREOF
11/14/60 | | 23c. NAME OF CEMETERY OR CREMATORY
Bakers Cemetery | | 23d. LOCATION (City, town, or county) (State)
Aberdeen, Maryland | | | |
| 24. FUNERAL DIRECTOR'S SIGNATURE
John J. Harring | | | | ADDRESS
Tarring Funeral Home
Aberdeen, Md. | | 25a. REC'D BY REGISTRAR
DATE NOV 16 '60 | | | |
| | | | | 25b. REGISTRAR'S SIGNATURE
Arthur S. Thomas | | | | | |

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15 (4)
ISM 9/59

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MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND
12633
12620
CERTIFICATE OF DEATH

| | | | |
|--|---------------------------|--|---------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>MD</u> b. COUNTY <u>Harford</u> | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First Middle Last <u>George Emanuel TriFILLIS</u> | | 4. DATE OF DEATH Month/Day/Year <u>11/16/60</u> 19 <u>60</u> | |
| 5. SEX <u>Male</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>3-24-11</u> |
| 9. AGE (In years last birthday) <u>49</u> yrs. | | 10. IF UNDER 1 YEAR Months Days Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Owner Manager</u> | | 10b. KIND OF BUSINESS OR INDUSTRY <u>Scrubber's Trailer Ct.</u> | |
| 11. BIRTHPLACE (State or foreign country) <u>MD</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>USA</u> | |
| 13. FATHER'S NAME <u>Emanuel TriFILLIS</u> | | 14. MOTHER'S MAIDEN NAME <u>Anna Kourouniotis</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <input type="checkbox"/> | | 16. SOCIAL SECURITY NO. <u>Valerie TriFILLIS</u> | |
| 17. INFORMANT <u>Valerie TriFILLIS</u> | | Address <u>4 Bros. Trailer Court, 401 1/2</u> | |
| 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>420.1</u> DUE TO <u>Coronary Occlusion</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) DUE TO _____
(c) _____ | | INTERVAL BETWEEN ONSET AND DEATH | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) | | 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) | |
| 20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>Sept 5</u> , 19 <u>60</u> , to <u>Nov 1</u> , 19 <u>60</u> , that (I) (we) last saw the deceased alive on <u>11-1-60</u> , and that death occurred at <u>12-00</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>Ch. F. Lemoine</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>11/19/60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>Angel Hill</u> | | 23d. LOCATION (City, town, or county) (State) <u>Harford, Md.</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Anthony P. Hand</u> | | 25a. REC'D BY REGISTRAR <u>DATE 21 '60</u> | |
| 25b. REGISTRAR'S SIGNATURE <u>Anthony P. Hand</u> | | | |

4451



1

INSTRUCTIONS

TO ATTENDING PHYSICIAN OR HOSPITAL: The law requires that the death certificate be executed within 24 hours after death. The bottom copy may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: The law requires that the death certificate be filed with the registrar within 72 hours after death. After this certificate has been executed by the attending physician and completely filled in by the funeral director, the third copy of this death certificate assembly should be detached for use as a burial transit permit.

VS A15C 1-55 10M

MARYLAND STATE DEPARTMENT OF HEALTH-BALTIMORE, 18

12615

CERTIFICATE OF DEATH

12621

Reg. Dist. No.

| | | | | | | | |
|--|-------------------------------------|---|---|--|------------------------------------|--|--|
| 1. PLACE OF DEATH | | | | 2. USUAL RESIDENCE (HOME) OF DECEASED | | | |
| COUNTY <u>HARFORD</u> | | STATE <u>MARYLAND</u> COUNTY <u>HARFORD</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u> | | CITY (If outside corporate limits, write RURAL and give nearest town) <u>BEL AIR</u> | |
| CITY OR TOWN <u>BEL AIR</u> | | LENGTH OF STAY (In this place) <u>Lifetime</u> | | STREET ADDRESS <u>230 N. BOND ST.</u> | | STREET ADDRESS (If rural give location) <u>230 N. BOND ST.</u> | |
| HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>230 N. BOND ST.</u> | | | | | | | |
| 3. NAME OF DECEASED (First) (Middle) (Last) | | | | 4. DATE OF DEATH (Month) (Day) (Year) | | | |
| <u>SARAH ELIZABETH WHITTINGTON</u> | | | | <u>NOV. 25 1960</u> | | | |
| 5. SEX <u>F</u> | 6. COLOR OR RACE <u>COL.</u> | 7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>DIVORCED</u> | 8. DATE OF BIRTH <u>OCTOBER 12, 1878</u> | 9. AGE last birthday <u>82</u> yrs. | IF UNDER 1 YEAR Months Days | IF UNDER 24 HRS. Hours Min. | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | | 11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u> | | 12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u> | |
| 13. FATHER'S NAME <u>LEVY WILSON</u> | | | | 14. MOTHER'S MAIDEN NAME <u>HANNAH BARRETT</u> | | | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unk.) <u>No</u> (If Yes, give war or dates of service) | | 16. SOCIAL SECURITY NO. | | 17. INFORMANT & ADDRESS <u>GENEVIEVE PEAKER, 230 N. BOND ST., BEL AIR, MD.</u> | | | |
| I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH | | | | 18. MEDICAL CERTIFICATION | | | |
| 1 <u>4221</u> IMMEDIATE CAUSE (A) <u>CONGESTIVE HEART FAILURE</u> | | | | INTERVAL BETWEEN ONSET AND DEATH <u>1 week</u> | | | |
| ANTECEDENT CAUSE(S) DUE TO (B) <u>ARTERIOSCLEROTIC CARDIOVASCULAR DISEASE</u> | | | | <u>20 years</u> | | | |
| DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST. DUE TO (C) | | | | | | | |
| 11 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <u>Chronic glomerular Nephritis; Bronchopneumonia</u> | | | | | | | |
| 19a. DATE OF OPERATION | | 19b. MAJOR FINDINGS OF OPERATION | | 20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/> | | | |
| 21a. ACCIDENT WAS UNDERLYING OR CONTRIBUTING CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 21b. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.) | | 21c. WHERE DID INJURY OCCUR? (City or town) (County) (State) | | | |
| 21d. TIME OF INJURY (Month) (Day) (Year) (Hour) (Min.) | | 21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | | 21f. HOW DID INJURY OCCUR? | | | |
| 22. I hereby certify that I attended the deceased from <u>APRIL 19, 1955</u> , to <u>Nov. 25, 1960</u> , that I last saw the deceased alive on <u>Nov. 24, 1960</u> , and that death occurred at <u>4:00 A.M.</u> from the causes and on the date stated above. | | | | | | | |
| SIGNATURE <u>Paul S. Stonecipher Jr.</u> | | ADDRESS (Street, city, town, state) <u>M.D. 115 FULFORD AVE., BEL AIR, MD.</u> | | DATE SIGNED <u>11/25/60</u> | | | |
| 23. BURIAL, CREMATION, REMOVAL (SPECIFY) <u>Burial</u> | | DATE THEREOF <u>Nov 28/60</u> | | NAME OF CEMETERY OR CREMATORY <u>Hendox Hill</u> | | LOCATION (City, town, or county) (State) <u>BEL AIR HARFORD MD</u> | |
| 24. REC'D BY REGISTRAR <u>NOV 28 1960</u> | | REGISTRAR'S SIGNATURE <u>Arthur S. Thomas</u> | | 25. FUNERAL DIRECTOR'S SIGNATURE <u>Joseph J. Foster</u> ADDRESS <u>Bel Air Md</u> | | | |
| DATE | | | | | | | |

CERTIFICATE OF DEATH

1911

Form No. 1

1. NAME OF DECEASED

JOHN J. HARRIS

2. SEX

Male

3. AGE

45

4. DATE OF BIRTH

1866

5. PLACE OF BIRTH

MD.

6. OCCUPATION

Farmer

7. CAUSE OF DEATH

Heart Disease

8. PLACE OF DEATH

Home

9. TIME OF DEATH

10:00 AM

10. SIGNATURE OF PHYSICIAN

J. H. HARRIS

11. SIGNATURE OF REGISTRAR

J. H. HARRIS

12. SIGNATURE OF WITNESSES

J. H. HARRIS

13. SIGNATURE OF DECEASED

J. H. HARRIS

14. SIGNATURE OF NEAREST RELATIVE

J. H. HARRIS

15. SIGNATURE OF CLERGYMAN

J. H. HARRIS

16. SIGNATURE OF MINISTER

J. H. HARRIS

17. SIGNATURE OF CHURCH

J. H. HARRIS

18. SIGNATURE OF BURIAL

J. H. HARRIS

19. SIGNATURE OF INTERMENT

J. H. HARRIS

20. SIGNATURE OF RECORD

J. H. HARRIS

21. SIGNATURE OF DEATH

J. H. HARRIS

UNLAWFUL TO REPRODUCE

may be required by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director on page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Board of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12634

MARYLAND STATE DEPARTMENT OF HEALTH
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

CERTIFICATE OF DEATH

12622

| | | | |
|---|---------------------------|---|----------------------------------|
| 1. PLACE OF DEATH
a. COUNTY <u>Harford</u> MARYLAND | | 2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission)
a. STATE <u>Penna</u> b. COUNTY <u>York</u> ✓ | |
| b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Harre-de-Grace</u> | | c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Delta</u> | |
| c. LENGTH OF STAY IN 1b <u>24 hrs.</u> | | d. STREET ADDRESS <u>Rt. # 2</u> | |
| d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Harford Memorial Hospital</u> | | e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input type="checkbox"/> | |
| 3. NAME OF DECEASED (Type or print) First <u>Baby</u> Middle <u>GIRL</u> Last <u>Young.</u> | | 4. DATE OF DEATH Month <u>11</u> Day <u>11</u> Year <u>1960</u> | |
| 5. SEX <u>Female</u> | 6. COLOR OR RACE <u>W</u> | 7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/> | 8. DATE OF BIRTH <u>11/10/60</u> |
| 9. AGE (In years lost birthday) yrs. <u>1</u> | | 10. IF UNDER 1 YEAR IF UNDER 24 HRS. Months <u>1</u> Days <u>1</u> Hours <u>3</u> Min. <u>5</u> | |
| 10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) | | 10b. KIND OF BUSINESS OR INDUSTRY | |
| 11. BIRTHPLACE (State or foreign country) | | 12. CITIZEN OF WHAT COUNTRY? | |
| 13. FATHER'S NAME <u>Richard S. Young.</u> | | 14. MOTHER'S MAIDEN NAME <u>Violet Sue Horton.</u> | |
| 15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) | | 16. SOCIAL SECURITY NO. <u>MR S Horton. PL. 2-4251.</u> | |
| 17. INFORMANT Address <u>MR S Horton. PL. 2-4251.</u> | | 18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).]
PART I. DEATH WAS CAUSED BY:
IMMEDIATE CAUSE (a) <u>RESPIRATORY FAILURE -</u>
DUE TO <u>HYALINE MEMBRANE DISEASE</u>
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>EXTREME PRE-MATURITY [BIRTH WT. 17g]</u>
DUE TO (c) <u>EXTREME PRE-MATURITY [BIRTH WT. 17g]</u> | |
| PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I(a) | | INTERVAL BETWEEN ONSET AND DEATH <u>3 HRS</u> | |
| 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/> | | | |
| 20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) | | 20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) <u>—</u> | |
| 20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u> | | 20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/> | |
| 20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) | | 20f. (City or town) (County) (State) | |
| 21. I certify that (I) (this hospital) attended the deceased from <u>19</u> to <u>19</u> , that (I) (we) last saw the deceased alive on <u>19</u> , and that death occurred at <u>19</u> M, from the causes and on the date stated above. | | | |
| 22a. SIGNATURE <u>AB Norman MD</u> | | 22b. DATE SIGNED | |
| 22c. PHYSICIAN'S NAME (Type) | | 22d. ADDRESS | |
| 23a. BURIAL, CREMATION, REMOVAL (Specify) | | 23b. DATE THEREOF <u>11-12-60</u> | |
| 23c. NAME OF CEMETERY OR CREMATORY <u>HARFORD MEMORIAL Hospital</u> | | 23d. LOCATION (City, town, or county) (State) <u>Harre-de-Grace Md</u> | |
| 24. FUNERAL DIRECTOR'S SIGNATURE <u>Harry R Tully Administrator</u> | | 25a. REC'D BY REGISTRAR | |
| 25b. REGISTRAR'S SIGNATURE | | DATE <u>NOV 21 '60</u> | |

1883

MASSACHUSETTS

1883

County of Suffolk
City of Boston

On the 10th day of April
1883, at the City of Boston

I, John J. ...
being a duly qualified

physician, do hereby certify that

the within and foregoing is a true and correct

statement of the facts and circumstances

connected with the death of

the person named above, and that the same

are true and correct to the best of my knowledge and belief.